Hoag Memorial Hospital Presbyterian

Community Benefit Report

2018

January 1st, 2018 – December 31st, 2018

OSHPD Facility ID #106301205

www.hoag.org

Board of Directors
Hoag Memorial Hospital Presbyterian
2018

Officers

Karen D. Linden, Chair
George H. Wood, Chair-Elect
Gary S. McKitterick, Immediate Past Chair
Raymond Ricci, MD, Secretary

Members

Vicki Booth
Robert Brunswick
Miles Chang, MD
Robert Evans
Dennis J. Gilmore
Paul Heeschen
Rodney Hochman, MD
Joel Katz, MD
Jeffrey H. Margolis
Pamela Massey
James Shepherdson
Cindy Stokke
Daniel Young

Medical Staff Officers

Michael Hurwitz, MD, Chief of Staff
Patty Huang, MD. Chief of Staff-Elect
Richard Haskell, MD, Immediate Past Chief of Staff

Senior Management Team

Robert Braithwaite, President and Chief Executive Officer
Michael Ricks, Executive Vice President and Chief Operating Officer
Carmella Cassetta, Interim, Chief Information Officer
Flynn Andrizzi, PhD, Senior Vice President, Development; President, Hoag Hospital Foundation
Jan Blue, Senior Vice President, Human Resources
Andrew Guarni, Senior Vice President, Finance
Kris Iyer, MD, Senior Vice President, CAO HMTS
Richard Martin, MSN, RN, EdD, Senior Vice President and Chief Nursing Officer
Sanford Smith, Senior Vice President, Real Estate, Facilities, Construction, & Operations

Hoag Memorial Hospital Presbyterian
Community Benefit Plan CY 2018

Table of Contents

EXECUTIVE SUMMARY

The Community Health department at Hoag Memorial Hospital Presbyterian was established in 1995. Since its beginning the program has focused on two principal strategies:

- Provide necessary healthcare-related services which are unduplicated in the community.
- Provide financial support to existing community based not-for-profit organizations which already provide effective healthcare and related social services to meet community health needs.

The Department of Community Health, led by its Director, Michaell Rose, DrPH is responsible for the coordination of Hoag's Community Benefit reporting, and provides free and low cost programs to assist the underserved in the community. These include Mental Health Services, Health Ministries Coordination, and a Grants Program. In addition to these services, many other Hoag departments provide community health services including education and support groups which are free/and or low cost to the community.

The Community Benefit program supports organizations that provide a broad range of services, including the following:

- Free/and or low cost medical and dental care
- Adult day care and education for persons who suffer from Alzheimer's disease or mild dementia, with support and education for their caregivers and families
- Transportation services for local senior centers
- Social and support services

Finally, Hoag provides uncompensated care (charity) to patients who are unable to pay for the full cost of their care. These expenditures amounted to over $48 million during CY 2018 (January 1, 2018 through December 31, 2018). Hoag's charity care and self-pay discount policy states that self-pay and uninsured patients who are unable to pay for the full cost of their care may qualify for charity or discounts on a sliding scale for incomes up to 400% of the federal poverty level.

Total quantifiable Community Benefit expenditures (excluding Medicare Cost of Unreimbursed Care) for CY 2018 amounted to over $63 million.

This report provides detailed descriptions of Hoag's Community Benefit programs and services, and includes quantifiable data for expenditures by programs during CY 2018.

CHAPTER I: HISTORY & COMMUNITY BENEFIT STRUCTURE

Introduction

The Hoag Memorial Hospital Presbyterian Community Benefit Program was formalized in 1995 and has grown significantly since that time. We have served over 90 nonprofit community organizations in a variety of health and social service categories. We continue to emphasize the development of sustained collaborative relationships and the provision of unduplicated services to disadvantaged residents in our community as core elements of the program.

Hoag's nonprofit regional health care delivery network consists of two acute-care hospitals – Hoag Hospital Newport Beach, which opened in 1952, and Hoag Hospital Irvine, which opened in 2010 – in addition to eleven urgent care centers and nine health centers, and has delivered a level of personalized care that is unsurpassed among Orange County's health care providers. Renowned for its excellence, specialized health care services and exceptional physicians and staff, Hoag is admired as one of California's leading hospitals. It is one of the county's largest employers with approximately 6,000 employees and more than 2,000 volunteers. Hoag's network of more than 1,700 physicians represents 52 different specialties.

Hoag is a designated Magnet® hospital by the American Nurses Credentialing Center (ANCC) and is fully accredited by DNV. Hoag offers a variety of health care services to treat virtually any routine or complex medical condition. Through its medical staff, state-of-the-art equipment and modern facilities, Hoag provides a full spectrum of health care services including five institutes that provide specialized services in the following areas: cancer, heart and vascular, neurosciences, women's health, and orthopedics through Hoag's affiliate, Hoag Orthopedic Institute, which consists of an orthopedic hospital and two ambulatory surgical centers.

To further Hoag's commitment to provide comprehensive care to the communities we serve, Hoag Medical Group was established in 2012 with the core values of excellence, innovation and compassion. The physician group comprises specialists and subspecialists in internal medicine, family medicine, pediatrics, geriatrics, acupuncture, neuromusculoskeletal, endocrinology, genetics, rheumatology, diabetes, allergy & immunology and HIV medicine. In 2013, Hoag entered into an alliance with St. Joseph Health to further expand health care services in the Orange County community, known as St. Joseph Hoag Health.

Hoag was the highest ranked hospital in Orange County in the 2018-2019 *U.S. News & World Report*. The organization was ranked the #4 hospital in the Los Angeles Metro Area and the #8 hospital in California. Hoag was the only Orange County hospital ranked in the top 10 for California. Additionally, Hoag was #23 nationally in Gastroenterology and GI Surgery, #31 nationally in Orthopedics, #41 nationally in Urology and #49 nationally in Geriatrics. Hoag ranked high performing in Cancer, Neurology & Neurosurgery, Nephrology and Pulmonology, as well as in all nine common adult procedures.

History

Hoag opened in 1952 as a community partnership between the Association of Presbyterian Members and the George Hoag Family Foundation, a private charitable foundation.

The George Hoag Family Foundation and the Association of Presbyterian Members represent the two founding organizations of the hospital and continue to provide leadership as corporate members of the Hoag Corporation. These members annually elect the Board of Directors, which consists of 17 members with representatives from the Hoag community and medical staff. The hospitals' Chief Executive Officer is also seated on the board as a voting member.

An annual meeting at the end of the fiscal year provides the corporate members the opportunity for the election/re-election of directors for the ensuing year.

Since its founding the hospital has welded a strong commitment to the community that it serves, including the provision of services for those who constitute a more vulnerable, at-risk population. Such care, for both inpatients and outpatients, is often only partially compensated. With excellence of management and the diligent stewardship of funds, Hoag has been able to sustain its financial strength. As a result, Hoag has been able to maintain a continuing commitment to quality of care while developing and expanding community programs and partnerships. Most of the funds expended upon Hoag's Community Benefit Program are from operating income.

For more information, visit www.hoag.org.

Mission, Vision, and Core Values

Hoag's Mission

Our mission as a nonprofit, faith-based hospital is to provide the highest quality health care services to the communities we serve.

Vision Statement

Hoag is a trusted and nationally recognized healthcare leader

Core Values

Excellence
Respect
Integrity
Patient Centeredness
Community Benefit

Hoag has identified six core strategies as a means to achieve our Vision and maintain our Mission and Values:

Quality and Service

Implement the Quality Management System to drive excellence throughout the organization.

People

Develop a performance-based and integrated culture of patients, physicians and staff.

Physician Partnerships

Create and maintain commitment to the Hoag community from exceptional doctors, through sustainable and satisfying leadership opportunities and mutually beneficial economic relationships.

Strategic Growth

Implement the continuum of care strategy to provide improved access, integration and experience and experiment with new business models to create sustainability for the future.

Financial Stewardship

Achieve enterprise wide growth and financial stability while directly reducing the cost of care.

Community Benefit and Philanthropy

Improve the health of vulnerable populations in Orange County.

Community Benefit Philosophy

We are encouraged by the better angels of our nature and the disposition of our hearts to think favorably of our fellows, regardless of their circumstances, and to serve them well: improving and sustaining their health and the quality of their lives and thus benefiting all.

The Department of Community Health provides direct services and collaborates with other not-for-profit community-based organizations to promote the health of our communities. The department coordinates Hoag's Community Benefit activities, driven by the health needs of our surrounding communities, which are regularly reviewed in an ongoing manner.

Hoag's Community Benefit Program is guided by five Core Principles:

1. *Emphasis on Disproportionate Unmet Health-Related Needs (DUHN)* - We concentrate on residents who have a high prevalence of severity for a particular health concern; and on residents with multiple health problems and limited access to timely high quality health care.
2. *Emphasis on Primary Prevention* – We focus on program activities that address the underlying causes of persistent health problems as part of a comprehensive strategy to improve health status and quality of life in local communities.
3. *Build a Seamless Continuum of Care* – We work to develop and sustain operational linkages between clinical services and community health improvement activities to manage chronic illnesses among uninsured and publicly insured populations.
4. *Build Community Capacity* – We target our charitable resources to mobilize and strengthen existing effective community health services.
5. *Emphasis on Collaborative Governance* – We emphasize *Networking* to exchange information; *Coordination* of synergistic activities; *Cooperation* in sharing resources; and *Collaboration* to enhance the combined capacity of our community health partners.

The department provides services which are unduplicated in the community. These currently include mental health services, case management, and the coordination of faith-based community nursing. In order to promote effective access to health care and related services, the department works in collaboration with a number of not-for-profit community based organizations to provide insurance coverage as well as free services to underserved and vulnerable residents, many of whom are undocumented. Charity care is an integral component of the benefit that Hoag provides to the community. The current hospital Charity Care and Self Pay Discount Policy provide assistance on a sliding scale for uninsured and self-pay patients with family incomes up to 400% of the Federal Poverty Level. The current Charity Care and Self-Pay Discount Policy is provided in Appendix A. Appendix B provides a summary of the quantifiable Community Benefit provided by Hoag in CY 2018 (January 1, 2018 to December 31, 2018). Appendix C provides a detailed breakdown of the Community Benefit expenditures by program.

Community Benefit Committee

The role of the Community Benefit Committee (”CBC”) is to establish, implement and monitor the policies and procedures that will provide the appropriate oversight and governance structure for the activities related to the Community Benefit Program at Hoag Memorial Hospital Presbyterian (“Hospital”).

The CBC is a Committee of the Hoag Memorial Hospital Presbyterian Board of Directors (the “Board”) and has the primary responsibility of ensuring that Hospital fulfills its moral and legal obligations to the community in serving the underserved and underprivileged through direct and indirect support of philanthropic health-related programs. CBC ensures that Hospital is in full compliance with federal and state regulations governing non-profit hospital organizations pertaining to community benefit and health-related activities.

The CBC ensures that Community Benefit activities are:

- Developed through engagement with community groups and local governmental officials in the identification and prioritization of community needs and to include mechanisms to evaluate the plan’s effectiveness.
- Aligned with the mission, vision and strategic objectives/initiatives of the Hospital,
- Consistent with the Hospital’s values and founding principles, and
- Developed with the input from Board, Administration and the Medical Staff leadership as appropriate.

The CBC is comprised of Hospital Board members and other members of the community and is supported by the senior management staff of the Community Health department.

Service Objectives

The service objectives of the Community Benefit program remain as initially defined:

- **Access:** To ensure adequate access to medical treatment through the availability of inpatient, outpatient and emergency medical services.
- **Services for Vulnerable Populations:** To provide health care services to uninsured, underinsured and indigent populations.
- **Education/Prevention:** To address the community health needs identified by the community health needs assessment through screening, prevention and education programs and services.
- **Research:** To provide new treatments and technologies to the local community through participation in primary clinical research.
- **Collaboration:** To establish and participate in collaborations which address community health priorities.
- **Coordination:** To provide case management services which coordinate medical and social services for vulnerable community residents.

CHAPTER II: COMMUNITY HEALTH NEEDS ASSESSMENT 2017

Overview

Hoag has undertaken a Community Health Needs Assessment (CHNA) as required by state and federal law. California Senate Bill 697 and the Patient Protection and Affordable Care Act and IRS section 501(r)(3) direct tax exempt hospitals to conduct a community health needs assessment and develop an Implementation Strategy every three years. The CHNA is a primary tool used by the hospital to determine its community benefit plan, which outlines how it will give back to the community in the form of health care and other community services to address unmet community health needs. This assessment incorporates components of primary data collection and secondary data analysis that focus on the health and social needs of the service area.

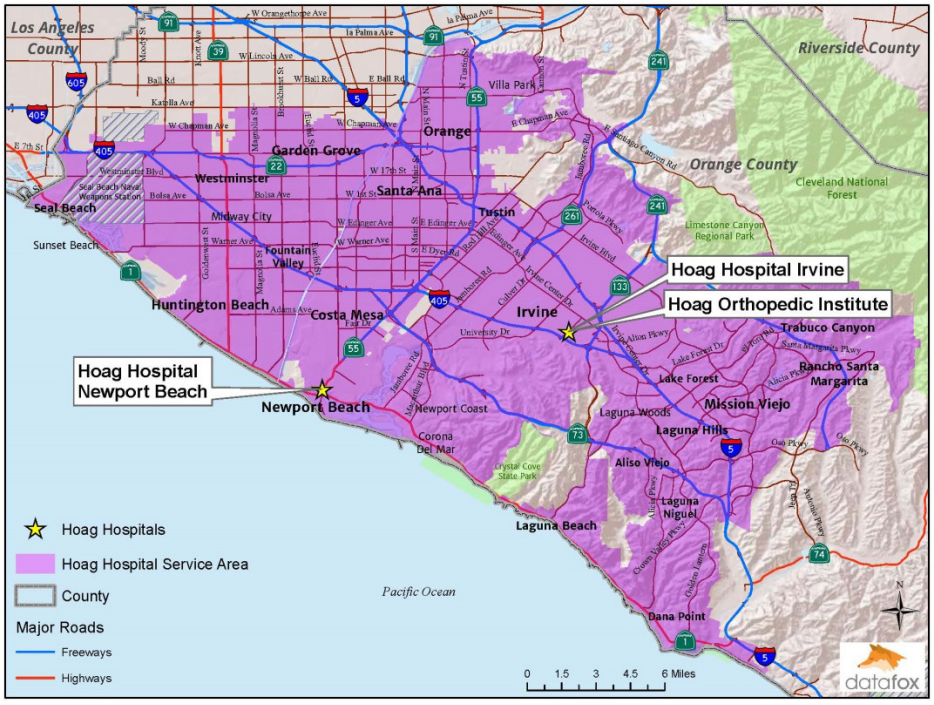
Service Area

Hoag Hospital Newport Beach is located at 1 Hoag Drive, Newport Beach, CA 92663.
Hoag Hospital Irvine is located at 16200 Sand Canyon Avenue, Irvine, CA 92618.
Hoag Orthopedic Institute is located at 16250 Sand Canyon Avenue, Irvine, CA 92618.

The Hospitals' service area is comprised of 27 cities/communities located in 53 zip codes. All of these zip codes are located in Orange County except for Long Beach (90803), which is in Los Angeles County. The community was determined by the zip codes of residence of the majority of patients who visited Hoag hospitals.

City	Zip Code	City	Zip Code
Aliso Viejo	92656	Midway City	92655
Corona Del Mar	92625	Mission Viejo	92691, 92692
Costa Mesa	92626, 92627	Newport Beach	92660, 92661, 92662, 92663
Dana Point	92629	Newport Coast	92657
Fountain Valley	92708	Orange	92866, 92867, 92868, 92869
Garden Grove	92843, 92844	Rancho Santa Margarita	92688
Huntington Beach	92646, 92647, 92648, 92649	Santa Ana	92701, 92703, 92704, 92705, 92706, 92707
Irvine	92602, 92603, 92604, 92606, 92612, 92614, 92617, 92618, 92620	Seal Beach	90740
Laguna Beach	92651	Sunset Beach	90742
Laguna Hills	92653	Trabuco Canyon	92679
Laguna Niguel	92677	Tustin	92780, 92782
Laguna Woods	92637	Villa Park	92861
Lake Forest	92630	Westminster	92683
Long Beach	90803		

Service Area Map



Joint CHNA

The IRS regulations allow for the conduct of joint Community Health Needs Assessments (CHNA) when hospitals define their service area communities the same. In compliance with these regulations, this CHNA was conducted jointly by Hoag Hospital Newport Beach, Hoag Hospital Irvine and Hoag Orthopedic Institute.

Project Oversight

The Community Health Needs Assessment process was overseen by:

Minzah Malik, MPH, MBA
Manager, Community Benefit Program
Community Health
Hoag Memorial Hospital Presbyterian

Lauren Tabios, MPH
Specialist, Grants & Special Projects
Community Health
Hoag Memorial Hospital Presbyterian

Consultant

Biel Consulting, Inc. conducted the Community Health Needs Assessment. Biel Consulting, Inc. is an independent consulting firm that works with hospitals, clinics and community-based nonprofit organizations. Dr. Melissa Biel conducted the Hoag Hospital Community Health Needs Assessment. She was joined by Sevanne Sarkis, JD, MHA, MEd, Sandra Humphrey and Denise Flanagan, BA. Biel Consulting, Inc. has extensive experience conducting hospital Community Health Needs Assessments and working with hospitals on developing, implementing, and evaluating community benefit programs. www.bielconsulting.com

Methodology

Secondary Data Collection

Secondary data were collected from a variety of local, county, and state sources to present community demographics, social and economic factors, health access, birth characteristics, leading causes of death, chronic disease, mental health, health behaviors, substance abuse and preventive practices. Analyses were conducted at the most local level possible for the service area, given the availability of the data. These data are presented in the context of Orange County and California State, framing the scope of an issue as it relates to the broader community.

Sources of data include: U.S. Census Bureau American Community Survey, California Health Interview Survey, California Department of Public Health, California Department of Education, California Employment Development Department, California Cancer Registry, California Office of Statewide Health Planning & Development, Community Commons, County Health Rankings, Orange County's Healthier Together, and others.

Secondary data for the hospital service area were collected and documented in data tables with narrative explanation. The tables present the data indicator, the geographic area represented, the data measurement (e.g. rate, number, or percent), county and state comparisons (when available), the data source, data year and an electronic link to the data source. Analysis of secondary data included an examination and reporting of health disparities for some health indicators. The report includes benchmark comparison data that measures Hoag Hospital's data findings with Healthy People 2020 objectives. Healthy People 2020 is a national initiative to improve the public's health by providing measurable objectives and goals that are applicable at national, state, and local levels.

Primary Data Collection

Targeted interviews and focus groups were used to gather information and opinions from persons who represent the broad interests of the community served by the hospital.

Interviews

Thirty-one (31) interviews were completed in December 2016 and January 2017. For the interviews, community stakeholders identified by Hoag Hospital were contacted and asked to participate in the needs assessment. Interviewees included individuals who are leaders and representatives of medically underserved, low-income, and minority populations, or local health or other departments or agencies that have current data or other information relevant to the health needs of the community served by the hospital facility. Input was obtained from Orange County Health Care Agency Public Health officials. At the beginning of each interview, the purpose of the interview in the context of the assessment was explained, the stakeholders were assured their responses would remain confidential, and consent to proceed was given.

Focus Groups

Three focus groups were conducted in January and February 2017 that engaged 50 persons. The focus group meetings were hosted by trusted community organizations. An agency contact was available to answer any questions at each focus group. At the beginning of each focus group, the purpose of the focus group and the community assessment were explained, the participants were assured their responses would not be attributed to them as responses would be aggregated. The focus group discussions were voice recorded for ease of documenting the discussion. Before beginning the discussion, the facilitator asked for oral consent from each of the participants that they wished to participate in the focus group and agreed to be voice recorded.

Initially, significant health needs were identified through a review of the secondary health data collected and analyzed prior to the interviews and focus groups. These data were then used to help guide the interviews and focus groups. The needs assessment interviews and focus groups were structured to obtain greater depth and richness of information and build on the secondary data review. During the data collection, participants were asked to identify the major health issues in the community, and socioeconomic, behavioral, environmental or clinical factors contributing to poor health. They were asked to share their perspectives on the issues, challenges and barriers relative to the significant health needs, and identify potential resources to address these health needs, such as services, programs and/or community efforts. The interviews and focus groups focused on these significant health needs:

- Access to Health Care
- Asthma
- Cancer
- Cardiovascular Disease
- Mental Health
- Overweight and Obesity
- Preventive Practices
- Substance Abuse

Analysis of the primary data occurred through a process that compared and combined responses to identify themes. All responses to each question were examined together and concepts and themes were then summarized to reflect the respondents' experiences and opinions. The results of the primary data collection were reviewed in conjunction with the secondary data. Primary data findings were used to corroborate the secondary data-defined health needs, serving as a confirming data source. The responses are included in the following Community Health Needs Assessment chapters.

Public Comment

In compliance with IRS regulations 501(r) for charitable hospitals, a hospital Community Health Needs Assessment (CHNA) and Implementation Strategy are to be made widely available to the public and public comment to be solicited. In compliance with these regulations, the previous Community Health Needs Assessment and Implementation Strategy were made widely available to the public on the website https://www.hoag.org/about-hoag/community-benefit/reports/. Public comment was requested on these reports. To date, no written comments have been received.

Priority Health Issues

Hoag Hospital hosted a community forum on February 28, 2017 in Newport Beach to prioritize the significant health needs. The forum engaged 35 community leaders in public health, government agencies, schools, and nonprofit organizations that serve the medically underserved, low-income, and minority populations in the community. These individuals have current data or other information relevant to the health needs of the community served by the hospital facilities. A list of the participants can be found in Attachment 3.

Priority Setting Process

A review of the significant health needs was presented at the community forum. The forum attendees were then engaged in a process to prioritize the health needs using the Relative Worth method. The Relative Worth method is a ranking strategy where each participant received a fixed number of points; in this case 100 points (5 dots equaled 100 points, where each dot was worth 20 points). Instructions were given, and the criteria for assigning points were explained. The points were assigned to health needs based on the size of the problem (relative portion of population afflicted by the problem); or seriousness of the problem (impact at individual, family, and community levels).

The points could be distributed among the health needs in a number of ways:

- Give all points to a single, very important item
- Distribute points evenly among all items (if none is larger or more serious than another)
- Distribute some points to some items, no points to other items

In the tabulation, the health needs were ranked in priority order according to the total points the group assigned. The top three ranked priority needs were: economic insecurity/housing/homelessness/transportation, mental health and access to care.

Community Health Needs Prioritized by CHNA
1. Economic insecurity/housing/homelessness/transportation
2. Mental health
3. Access to health care
4. Preventive practices
5. Substance abuse
6. Overweight and obesity/Diabetes
7. Cancer
8. Cardiovascular disease
9. Asthma

Participants engaged in a group discussion about the priority areas and were asked to discuss the following questions for the high priority areas:

- For priority issues, what is going well? What works in the community to address this issue?
- Who has plans to work on these issues over the next year?

The information gathered from the community forum will be used for decision making in creation of the Implementation Strategy.

Impact Evaluation

In 2015, Hoag Hospital conducted their previous Community Health Needs Assessment (CHNA). Significant health needs were identified from issues supported by primary and secondary data sources gathered for the Community Health Needs Assessment. In developing the hospitals' Implementation Strategies associated with the 2015 CHNA, Hoag Hospital Newport Beach and Hoag Hospital Irvine chose to address access to health care, chronic disease management, mental health and preventive care through a commitment of community benefit programs and resources. Hoag Orthopedic Institute focused its Implementation Strategy on arthritis and osteoporosis. The evaluation of the impact of actions the hospitals used to address these significant health needs can be found in Attachment 4.

Regional Priority

As part of the definitive agreement for the St. Joseph Health Hoag (SJHH) affiliation, a commitment was made to reduce health disparities in the communities we serve. In 2016, a regional SJHH health disparities needs assessment was completed and a plan approved in 2017 to address the disparities. One of the plan action steps is the identification of a regional priority for SJHH to address the issue of education equity in our communities. This priority will be incorporated in the SJHH Community Benefit Strategy and Implementation Plan for 2018-2020.

Implementation Strategy 2018-2020

Implementation Strategy Development
The Implementation Strategy was developed with input from the hospital Community Benefit Committee and the Department of Community Health. The following criteria were used to determine which significant health needs Hoag hospital facilities will address in the Implementation Strategy:

- Organizational Capacity: There is capacity to address the issue.
- Existing Infrastructure: There are programs, systems, staff and support resources in place to address the issue.
- Ongoing Investment: Existing resources are committed to the issue. Staff time and financial resources for this issue are counted as part of our community benefit effort.
- Focus Area: Has acknowledged competencies and expertise to address the issue and the issue fits with the organizational mission.

As a result of the review of needs and application of the above criteria, Hoag will address: access to care; economic security; mental health; chronic disease prevention, including obesity prevention and chronic disease management, through a commitment of community benefit programs and charitable resources.

Access to Care
Access to health care affects a person's health and well-being. Reliable access to health services can prevent disease and disability, reduce premature death and increase quality of life. Health insurance coverage is considered a key component to accessing health care. The service area insurance rate is 84.7%. In Orange County, 49.9% of the population has employment-based health insurance; 19.4% are covered by Medi-Cal and 11.3% of the population has coverage that includes Medicare. Delayed care may also indicate reduced access to care; 11.3% of Orange County residents reported delaying or not seeking medical care and 10.8% reported delaying or not getting their prescription medication in the last 12 months.

Community input on access to care indicated that while more persons now have insurance coverage as a result of the Affordable Care Act, insurance copays are high and necessary care isn't always covered. Many people may access care in the ED because they do not have a primary physician who can see them in a timely manner.

Chronic Disease
Chronic disease encompasses a wide range of health issues including, arthritis, diabetes, cardiovascular disease, cancer and asthma, among others. In Orange County, cancer, heart disease and Alzheimer's disease were the top three leading causes of death (age-adjusted, 2011-2013). Diabetes is a growing concern in the community; 7.1% of adults in Orange County have

been diagnosed with diabetes, and 9.2% have been diagnosed as pre-diabetic. In Orange County, 10.7% of the population has been diagnosed with asthma in their lifetime. 93.2% have had symptoms in the past year, and 48.9% take daily medication to control their asthma. Among Orange County youth, 17.2% have been diagnosed with asthma in their lifetime, 39.6% have visited the ER as a result of their asthma, and 60.1% take daily medication to control their asthma.

Community stakeholders noted that living in poverty is a big stressor that leads to chronic diseases. There is a lack of access to preventive practices. People don't have time for exercise and they do not have access to fresh fruits and vegetables. Being overweight has a tremendous impact on chronic disease. Policies are needed on land use, access to fruit and vegetables, and environments that are safe to be physically active in. This will impact the root causes of chronic diseases. There needs to be an emphasis on prevention and lifestyle changes to reduce chronic diseases.

Economic Security

Education, adequate employment and housing are components that provide a level of economic security for individuals and families. Among area residents, 12.5% are at or below 100% of the federal poverty level (FPL) and 28.8% are at 200% of FPL or below (low-income). Examining poverty levels by age group indicates that 16.4% of children in the service area live in poverty and 8.7% of seniors live in poverty. In the service area, the high school graduation rate is 92%. Of the population age 25 and over, 15.3% in the service area have not attained a high school diploma.

Stakeholders noted that poverty, poor housing, racism, lack of education and unemployment all impact the health of the community. There are socioeconomic disparities in Orange County, which result in low-income populations who lack adequate health care coverage, housing and education. Inadequate transportation in Orange County impacts individuals' ability to access jobs, health care and social service resources.

Mental Health

Mental illness is a common cause of disability and may result in individuals at-risk for substance abuse and violent behavior. In Orange County, 6.3% of adults experienced serious psychological distress in the past year. Among adults, 9.9% saw a health care provider for emotional, mental health, alcohol or drug issues, however, 55.3% of those who sought or needed help did not receive treatment. In Orange County, 33.1% of teens needed help for an emotional or mental health problem.

Community stakeholders shared that among refugees mental health is a taboo topic. There are gaps in resources for people with mental health issues, including an access barrier for people of different cultures and languages. Mental health issues are underdiagnosed in the poorest populations and there is a lack of quality services addressing these needs. In Orange County, there are not enough areas to admit patients in psychiatric crisis or enough places to go for care. Patients continue to worsen and the only place to go is the ED because they are gravely disabled, homicidal or suicidal.

Prioritized Community Health Needs	Needs Selected by the Hospitals	Criteria for Selecting Needs	Needs Not Selected
• Economic Security: Housing, Homelessness, Transportation • Mental Health • Access to Health Care • Preventive Practices • Substance Abuse • Overweight and Obesity • Cancer • Cardiovascular Disease • Asthma	• Economic Security: Housing, Homelessness, Transportation • Mental Health • Access to care • Prevention and Management of Chronic Disease (Includes Overweight and Obesity)	• Organizational Capacity • Existing Infrastructure/ Partnerships • Ongoing Investment • Focus Area	• Substance Abuse

Hoag's Implementation Strategy

The Implementation Strategy was developed with input from the Community Benefit Committee and the Department of Community Health. For each health need the hospitals plan to address, the Implementation Strategy describes: actions the hospitals intend to take, including programs and resources it plans to commit; anticipated impacts on these actions; and planned collaboration with other organizations.

Health Need: Economic Security
Strategies
1) Research the existing organizations and resources available (i.e. housing, homelessness, transportation, career development) to identify community assets and gaps. (HHNB, HHI) 2) Provide funding and/or in-kind support to community nonprofit organizations that focus on economic security measures. (HHNB, HHI)[1] 3) Build community capacity by providing collaborative partners with space and resources at the Melinda Hoag Smith Center for Healthy Living. (HHNB, HHI)
Expected Outcomes for this health need
• Increase access to supportive services for individuals and families to help them maintain stability and self-sufficiency. • Leverage Hoag assets to build capacity among community organizations to improve food, housing, employment and education among at-risk populations.

[1] Indicates each hospital's particular role in taking action to address the significant health needs: HNB = Hoag Newport Beach; HI = Hoag Irvine; HOI = Hoag Orthopedic Institute.

Health Need: Mental Health
Strategies
1) Provide mental health care services through Hoag's Mental Health Center primarily focused on the low-income population. (HHNB, HHI) 2) Provide funding and/or in-kind support to community nonprofit organizations that focus on mental health that goes beyond our scope of care. (HHNB, HHI) 3) Provide workforce development opportunities (internships, internal and external professional development). (HHNB, HHI) 4) Use existing pathways to expand our continuum of care. (HHNB, HHI)
Expected Outcomes for this health need
• Increase access and remove barriers to mental health care services in community settings. • Provide bilingual, bicultural mental health care services to people who otherwise could not obtain mental health services. • Bridge gaps, improve referrals and increase coordination among mental health care providers and community resources and programs. • Leverage Hoag assets to build capacity among community clinics and community organizations to improve access to mental health care.

Health Need: Access to Care
Strategies
1) Provide financial assistance through free and discounted care for health care services, consistent with the hospital's financial assistance policy. (HHNB, HHI) 2) Offer information and enrollment assistance for no cost and low-cost insurance programs. (HHNB, HHI) 3) Provide funding and/or in-kind support to community clinics. (HHNB, HHI) 4) Provide in-kind support to community clinics for orthopedic surgeries. (HOI) 5) Provide funding and/or in-kind support to community nonprofit organizations that reduce barriers to accessing care. (HHNB, HHI) 6) Provide partners with space and resources at the Melinda Hoag Smith Center for Healthy Living. (HHNB, HHI) 7) Provide transportation support for seniors to increase access to health care services. (HHNB, HHI)
Expected Outcomes for this health need
• Increase access to primary health care and a medical home. • Bridge gaps, improve referrals and increase coordination among health care providers and community resources and programs. • Leverage Hoag assets to build capacity among community clinics and community organizations to improve access to health care.

Health Need: Prevention of Chronic Disease and Management
Strategies
1) Provide funding and/or in-kind support to community clinics. (HHNB, HHI) 2) Provide funding and/or in-kind support to community nonprofit organizations that focus on disease prevention, including obesity prevention and chronic disease management. (HHNB, HHI) 3) Provide partners with space and resources at the Melinda Hoag Smith Center for Healthy Living. (HHNB, HHI) 4) Offer chronic disease prevention, management, education, screenings and support groups. (HHNB, HHI) 5) Support the Faith Community Nursing Program to provide wellness and prevention programs among congregations in Orange County. (HHNB, HHI) 6) In partnership with Mary & Dick Allen Diabetes Center, provide comprehensive diabetes prevention and treatment services, obesity prevention, and pediatric specialty care for children with diabetes. (HHNB, HHI) 7) Promote bone health in community to maintain an active lifestyle. (HOI) 8) Provide funding and/or in-kind support for Wellness Initiative. (HOI)
Expected Outcomes for this health need
• Improve individuals' compliance with chronic disease prevention and management recommendations. • Increase community awareness of disease prevention strategies. • Leverage Hoag assets to build capacity among community clinics and community organizations to improve chronic disease management among at-risk populations. • Provide access to needed health promotion resources for vulnerable populations at-risk for or suffering with chronic diseases. • Maintain and expand Own the Bone program. • Continue Fall Risk Assessments at health fairs. • Continue health education efforts – e.g. public school presentations, community lectures, on-line education. • Continue physician and healthcare provider education.

Regional Initiative

In addition to Hoag's individual hospital priority health needs and strategies, Hoag will include a focus on education equity, as part of Providence St. Joseph Hoag Health's regional community need to be addressed. The initiative on regional education equity will focus on low income populations, with the goal of reducing the education achievement gap in the schools. Hoag's strategy will be to identify and participate in local collaboratives, engaging with existing collaborative partners in developing a plan to improve Early Development Index scores.

Planned Collaboration

To accomplish these strategies Hoag will collaborate with community partners. Sharing resources and enhancing the capacity of partner organizations supports the achievements of our goals. Potential collaborative partners include, but are not limited to:

Advocacy Groups	Community Health Centers and community clinics
Community-based organizations	Faith based organizations
Family Resource Centers	Mental Health Associations
Orange County Health Care Agency	School districts and schools
Local Food Banks	Senior centers and adult day centers

Evaluation of Impact

Hoag will monitor and evaluate the programs and activities outlined above. The hospitals anticipate the actions taken to address significant health needs will improve health knowledge, increase wellness behaviors; increase access to health and mental health care; and support self-sufficiency among vulnerable populations. The hospital is committed to monitoring key initiatives to assess impact and has implemented a system that tracks the implementation of the activities and documents the anticipated impact.

The reporting process includes the collection and documentation of tracking measures, such as the number of people reached/served, increases in knowledge or changes in behavior as a result of planned strategies, and collaborative efforts to address health needs. An evaluation of the impact of the hospitals' actions to address these significant health needs will be reported in the next scheduled CHNA.

CHAPTER III: DEPARTMENT OF COMMUNITY HEALTH PROGRAMS

The department of Community Health provides direct Community Benefit service programs and coordinates Community Benefit reporting at Hoag Hospital. This section of the report provides information for each of the Community Health programs and achievements in CY 2018 (12 months): January 1, 2018 - December 31, 2018.

Mental Health Center

The Mental Health Center was created to provide bilingual bicultural services to people who otherwise could not obtain mental health services. The majority of the clients are low-income, uninsured and highly vulnerable and present with a mild to moderate level of distress/symptomatology. These clients have limited health insurance with no mental health/behavioral health benefits or they have benefits but cannot afford the co-payments and/or deductibles.

During CY 2018, the program employed six full-time, one part time and two per diem bilingual Master's prepared social workers, 5 of the staff are licensed. These social workers provided mental health services to 710 clients in the form of psychotherapy. Resource brokering, and/or case management was provided to 205 individuals. In addition, the program offered psychotherapeutic, psycho educational groups and community presentations which resulted in 1,862 encounters. All services were offered on a voluntary basis. Services were offered on a low-cost sliding scale. The sliding scale starts at zero (free services) and increases according to the individual's self-reported annual income level. The vast majority of people were seen at no charge or at a nominal fee per session. A review of client demographics found that the majority of the clients seen through the Mental Health Center were female, Hispanic, and indicated a language other than English as their primary language. The average client age for our adult population was 38.9 years of age and the average age of the minor population was 14.8 years of age. 59% percent of the adult clients and 45% of minor clients reported having an annual household income below $20,000.The program has proven to be highly efficient and effective. The program utilized a clinical assessment tool (DASS) to measure levels of depression, anxiety, and stress in clients. According to pre and post test scores, clients who participated in either individual or group psychotherapy saw a statistically significant decline in depression, anxiety, and stress scores. The program also implemented a self-esteem assessment tool (Rosenberg) on a pre and posttest basis. Across the board for individual and group psychotherapy, there was statistically significant improvement in self-esteem.

In addition to direct mental health services to the community we also provided professional development trainings to mental health professionals for free. A sampling of the trainings offered included: ASIST for suicide assessment and intervention, Dialectical Behavior Therapy Training, Critical Incident Stress Management training, NAMI Provider training and Law and Ethics. The number of professionals trained for CY 2018 was 1,168.

In CY 2018, the Mental Health Center provided a supervised clinical internship training program for 8 MSW (Master of Social Work) students. During the academic year the interns provided a total of 5,500 clinical hours. The center collaborates with the University of Southern California, California State University at Fullerton and California State University at Long Beach. Each intern was provided with weekly one hour long supervision and one and a half hour long group supervision for a total of 306 direct clinical supervision hours provided to the group. The internship program includes providing consultation, support, and education to paraprofessionals at partner agencies such as Girls Incorporated and the Newport Mesa Unified School District.

This support included telephone consultation, workshops, and in-service education. In addition to support for the staff of partner agencies, the Mental Health Center offered several different psychotherapeutic and psycho educational groups and workshops for the partner agency clients. These efforts allowed our partner agencies to offer mental health services at no cost to their clientele and all services are provided in-kind to the not-for-profit agencies. Some examples include: a diabetes support group, depression support groups, self-esteem groups, and stress management workshops. Group sessions were also offered for parents, families, and adult couples struggling with relationship issues. Lastly, the Mental Health Center's part time Psychiatrist had 260 consultation appointments during the fiscal year.

Contact: Rocio Valencia Vega, LCSW at 949 764-8547 or Rocio.ValenciaVega@hoag.org

Community Benefit Grants Program

Hoag's Community Benefit Grants Program serves to reinforce Hoag's mission as a non-profit, faith-based hospital, providing the highest quality health care services to the community. The Community Benefit Grants Program focuses on meeting the unique needs of Orange County residents, with particular emphasis upon the disadvantaged and underserved. Every year, the program provides grants to community organizations who strive to meet the health and social service related needs of the Orange County community.

Eligibility for the program is dependent on the organization and the program funding is sought after. The eligibility criteria consist of:

- Organization must have operations in Orange County, CA
- Must be 501(c)(3) tax exempt organization, local government entity, or education institution
- Services are provided to disadvantaged and/or underserved populations
- Services must align with at least one of the four Priority Areas listed
- Services are provided within the geographic boundaries of Orange County, CA
- Priority will be given to organizations that recognize the need for partnership and collaboration with other organizations that are meeting critical needs

The Priority Focus Areas are determined by the Community Health Needs Assessment, conducted every three years. The needs are identified first through secondary data for the county, and then narrowed to significant health needs using input from persons representing the broad interests of the community, as well as persons with special knowledge or expertise in public health. The significant health needs are then prioritized into the Priority Focus Areas that the hospital will plan on addressing through programming and services. The Priority Focus Areas for the Community Benefit Grants Program CY18 were:

- Access to Care for Vulnerable Populations
- Chronic Disease Management
- Mental Health
- Preventive Health

CY 2018 included an 18-month grant cycle, from July 1, 2017 – December 31, 2018. The grant cycle usually falls on a 12-month period following the fiscal year; however, Hoag's fiscal year changed, resulting in a longer grant period.

If awarded, funds must be used specifically for the designated program outlined in the grant application. Organizations that do receive funding are required to submit a progress report, as well as a final outcomes report.

During CY 2018, 92 grants were funded, with the following breakdown for the Priority Focus Areas:

Priority Area	Grant Count
Access to Care for Vulnerable Populations	32
Chronic Disease Management	9
Mental Health	20
Preventive Health	31
Total	**92**

Contact: Lauren Tabios, MPH at (949) 764-5321 or Lauren.Tabios@hoag.org

Health Ministries

The Hoag Health Ministries Faith Community Nursing (FCN) program is integral in supporting Hoag's mission as a faith-based hospital. Seventy primarily volunteer FCNs are providing professional nursing services at 46 congregations throughout Orange County. The Hoag Health Ministries program has provided leadership and training to the community-based RNs for over 30 years. Each FCN works independently within his/her congregation in creating individual and population health based preventive health programs specific to the needs, beliefs, and practices unique to their faith traditions. All denominations are welcome to participate in this spiritually centered wellness program, which seeks to incorporate a balance of the mind, body, and spirit. Hoag's program also serves as a role model for other Health Ministries - FCN programs throughout the western state region, and has participated in national and international health care training initiatives.

Year to Date, CY 2018 accomplishments include:

- Welcomed 4 new churches into the Hoag program
- 10 denominations included amongst the 46 Faith Based Partnerships, located within a 300 square mile area throughout Orange County
- Donated countless volunteer RN hours at the local, national and international level
- Touched the lives of more than 50,000 congregants:
    - Through individual case management & support group services
    - Clinical services – Flu vaccines, BP screenings, Blood Drives
    - Community health education programs, including Whole Person Care, end of life initiatives in collaboration with the OC Diocese
- Other services included home/hospital visits, program planning & volunteer coordination
- Administered 8,900 flu vaccine doses to faith members and the community
- Served 222 congregants with spiritually based aging and dementia care health education c
- Trained 293 persons in life-saving CPR & Automated External Defibrillator usage
- Over 260 units of life saving blood collected through Hoag Blood Mobile services
- Provided 4 Foundations of Faith Community Nursing courses; trained and commissioned 32 FCNs in the 36 hour course at Hoag, Trinity Presbyterian Church Santa Ana, St Mary's Hospital Apple Valley, St Joseph's Hospital Burbank
- Developed the annual *Spirituality Conference: Unity, Health and Hope*, attended by 200 health care professionals, religious leaders and caregivers
- Provided a first time Nurses Retreat in honor of Nurses Week and the service provided by the Hoag Health Ministries partner FCNs, focusing on Self-Care
- Hosted the FCN Summit Meeting in collaboration with St Mary's Hospital Apple Valley and Providence St Joseph Institute for Human Caring, focusing on end of life discussions, drawing 119 RN participants from southern CA
- Developed a Nurse Health & Wellness Coaching initiative; 1 RN completed national certification as a Nurse Coach
- Deployed NurseDot, a documentation system required by FCNs

Contact: Susan Johnson, RN-BC, MPH at (949) 764-6594 or Susan.Johnson2@hoag.org

Project Wipeout

Project Wipeout was created to provide beach and water safety information to the nearby beach communities after seeing an increased incidence of spinal cord injuries in the Hoag Newport Beach Emergency Department. The program was developed to provide education highlighting prevention of spine injuries. Over time, education efforts have transitioned towards beach and water safety and overall injury prevention for both beach safety service providers and the general public. It's mission has evolved to inspire water safety culture at the beach and beyond through education and community outreach. Education topics include drowning prevention, rip current safety and escape, marine animal behavior and safety, beach hazards, best practices in the water, and sun protection.

Project Wipeout partners and collaborates with members of the beach safety community, which includes the lifeguard and fire department for the county and city agencies throughout Orange County, the California Surf Life Saving Association and other lifesaving agencies. Additionally, Project Wipeout works closely with the Orange County Lifeguard Chiefs Association, the Orange County Drowning Prevention Taskforce, and other county-wide collaboratives. In CY 2018, Project Wipeout launched partnerships with the cities of Irvine and Newport Beach, as well as with multiple nonprofit organizations. At the national level, Project Wipeout has started to collaborate with the United States Lifesaving Association. Globally, Project Wipeout has gained recognition as a drowning prevention entity, participating in the National Drowning Prevention Alliance's International Rip Current Symposium.

Program highlights from CY 2018:

Lifeguard Symposium

In CY 2018 Stub, Project Wipeout hosted the annual Lifeguard Education Symposium, with over 315 attendees, which included lifeguards and fire personnel from all over Orange County. CY 2018 marked the establishment of live streaming the conference to different sites: Seal Beach and San Clemente. An additional 70 lifeguards and life-saving personnel viewed the live stream at the two live stream locations. The conference continues to grow each year, and serves as an opportunity for lifeguards and other first responder service providers to receive education on current beach and water safety information, that can be integrated into their training and safety responses. Additionally, the conference intends to address health and wellness topics pertinent to beach exposures for personnel working and responding on the beach, as well as professional development in the field.

Beach Safety Curriculum

In CY 2018, the beach safety presentation and curriculum developed to present to schools was finalized. The presentation was completed through collaborative content development by the Project Wipeout Advisory Committee, which included expert content analysis and new videos and pictures. The beach safety presentation includes a pre-test, worksheet, and a post-test to help evaluate changes in knowledge. In CY 2018, the presentation was piloted in the city of San Clemente, Crystal Cove State Parks, and Huntington State and Seal Beach Junior Guard summer

programs. Pre-and post-tests collected at the Crystal Cove State Parks youth pilot study indicate a statistically significant change in knowledge for beach and water safety.

Eyes Save Lives Pool Safety Presentation

Project Wipeout partnered with Hoag Irvine's Emergency Department (ED) nurse project, Eyes Save Lives, to create a pool safety presentation, to be shared with the community. Eyes Save Lives has been a passion project for Hoag Irvine's ED to bring awareness towards pool drowning and prevention. As part of the collaboration, Project Wipeout has been able to formally oversee the research and development of the pool safety presentation, as well as the materials provided to participants for each presentation.

In CY 2018, Project Wipeout focused an Eyes Save Lives pilot targeting parents and caregivers for children. The pilot identified swim school lessons as an opportunity to reach a captive audience. In June-August CY 2018, Project Wipeout completed the pilot study with the following breakdown:

- 59 pool safety presentations for the cities of Irvine and Newport Beach
- 443 parents/caregivers received the presentation and resource packet
- 176 pre-test surveys were completed
- 45 follow up post-test surveys were completed

An analysis of the pre-and post-test surveys revealed statistically significant increases in pre-post water safety knowledge and attitudes, and self-efficacy in responding to a water emergency.

Outreach Events

During CY18 Stub, Project Wipeout's main community outreach took place at the Melinda Hoag Smith Center for Healthy Living Family Health Day, Imaginology, as well as at smaller city community events, with almost 2000 encounters. These encounters consists of personal interactions between lifeguards, educators, children, and families that included distribution of beach safety materials and activities. In addition to these large events, Project Wipeout materials are used by local lifeguards at each agency's headquarters, both as education materials for beach visitors and as training for the junior guard programs. Materials are available in both English and Spanish, and have been previously sent out nationally and internationally, as teaching tools for different water safety agencies outside of California, such as within New Zealand and Baja California. All materials are available to download for free from the Hoag Project Wipeout website:www.hoag.org/projectwipeout.

Contact: Lauren Tabios, MPH at (949) 764-5321 or Lauren.Tabios@hoag.org

Melinda Hoag Smith Center for Health Living

The city of Costa Mesa has been identified as a resource desert due to an absence of sufficient resources to address key health determinants in the community. In order to help address these health determinants in our community, Hoag has created a synergistic model of service delivery, which not only addresses the lack of resources but also seeks to bridge gaps between services. This service delivery model has helped facilitate collaboration and build capacity in our community partner agencies, by providing non-profit partners with physical space and resources within the Melinda Hoag Smith Center for Healthy Living. Since opening in 2016 our collaborative has grown extensively and now includes the following:

Hoag's Mental Health Center	Alzheimer's OC
Hoag's Health Ministries	Orange County Council on Aging
SOS Children & Family Health Center	Big Brothers Big Sisters
SOS Dr. Robert & Dorothy Beauchamp Child and Family Dental Center	Serving People In Need
OC Public Health Nursing	Project Self Sufficiency
Public Law Center	Vital Aging
National Alliance for the Mentally Ill	CIELO
Be the Change Yoga	MOMs Orange County
ASPIRE	Human Options
Susan G. Komen OC	Girls Inc.
Youth Employment Services	Children's Bureau
OC Bar Foundation	CHOC PODER

The Melinda Hoag Smith Center for Healthy Living has provided space to like-minded community agencies, who seek to improve the quality of lives of those in the community. A key component which makes the collaborative unique and is essentially the glue between the community and the center, is our centralized registration and case management team. This team assures that all client's coming into the center fill out a screener which seeks to identify; socio-economic stressors, potential health risks, mental and emotional health issues, legal issues, access to health care, and other life stressors that can affect ones quality of life. Our case-management team plays a critical role in linking clients to the appropriate services, while also monitoring client's progression through the referral process. This model for service delivery helps bridge gaps between community, clients and agencies, while also leveraging resources and the fostering collaboration between organizations. The Melinda Hoag Smith Center for Healthy Living's co-location of resources has created a cohesive, one-stop, welcoming environment where community members can find a breadth of services and support. In CY 2018, 1870 Individuals and/or families registered as members or inquired about services and were linked to appropriate agencies through our case manager support team. Some highlights from CY 2018's provision of resources and services include:

Life skills and youth support services

- 205 people were CPR certified. This helped for job security and placement for several nannies, child care workers, and preschool teachers.
- 331 adults participated in Cielo's entrepreneurship/ job readiness classes.
- 2699 encounters for Girls Inc's after school homework lab and STEM activities (boys and girls)

Health driven classes focusing on improved health and decrease in obesity

- 8275 encounters for yoga and Zumba classes
- 297 encounters for children participated in ballet classes
- 1564 encounters for children participated in Amigitos/Zumbini

Education and support to individuals and families affected by mental illness

- 1763 People participated in a NAMI class/support group
- 8194 individuals were either visited at home or met with a Promotora onsite to discuss mental health services, starting in September of 2018.

Legal Aid and Representation

- 326 People have received legal consultation or representation from the public law center (lawyer started 20 hours a week on site since May). Free legal representation is key because this is the service that is in highest demand and is least available in the community. We are focusing on Family Law – divorce, DV, child custody etc.

In CY 2018, the Melinda Hoag Smith Center for Healthy Living hosted a number of events that included the annual health fair, Family Health Day. The health fair was attended by 557 individuals that included adults and children. Attendees participated and received various services including: mental health resources, flu shots, dental cleaning, blood pressure, and diabetes screening.

The Melinda Hoag Smith Center for Healthy Living fosters a community collaboration, not only with its non-profit partners on-site, but also with outside agencies. Through the Center's Professional Network Resource Exchange monthly meetings, 310 individuals represented their agencies and networked with other nonprofit organizations in the county.

Contact: Arturo Diaz, LCSW at (949) 764-6578 or Arturo.Diaz@hoag.org

CHAPTER IV: OTHER HOAG COMMUNITY BENEFIT ACTIVITIES

The Mary & Dick Allen Diabetes Center

An estimated 57% of our primary service area is impacted by diabetes or pre-diabetes. According to the American Diabetes Association, the number of those affected by diabetes and the related costs, are expected to double by 2030. In an effort to meet the needs of these patients, the Mary & Dick Allen Diabetes Center was opened in 2009 and has offered services that include health
Education and support from certified diabetes educators, nurses, dietitians, and clinical social workers, medication management by pharmacist educator and nurses, and clinical evaluation by the endocrinologist. The Center participated in various outreach events at local senior centers, diabetes risk assessments at health fairs, and cooking demonstrations in the community. Some of our highlight for calendar year 2018 are listed below:

Program highlights from CY18

1) Recruitment of new Endocrinologist, David Ahn
2) Opening of second Diabetes Center in Irvine
3) Tele-health education classes offered to Mother's with gestational diabetes
4) In partnership with PADRE Foundation, peer support groups for youth/young adults with T1D and families offered quarterly
5) Peer support groups for T2DM offered monthly
6) Diabetes Prevention Program offered (Viviendo Saludable, Healthy Lifestyle Program for those with Prediabetes)
7) Free psychosocial consults (with a licensed social worker) for all patients with diabetes

Behavioral Research Program

The Center pursued various research studies in 2018 lead by Harsimran Singh, PhD, clinical research scientist and health psychologist. The Center's research studies have been published in 6 peer-reviewed publications and scientific journals, and Dr. Singh has presented 7 scientific presentations including conferences hosted by the Society of Behavioral Medicine, and the American Association of Diabetes Educators. Topics covered a wide range in diabetes including clinical and psychological health in Hispanic women with pre-diabetes, value of psychosocial health in pregnancy with diabetes, assessing the needs of a diverse community of people with type 2 diabetes in terms of health education, and preparing patients psychologically for their visit with their diabetes care team.

Diabetes Self-Management Education and Support (DSMES)

Diabetes Self-Management Education and Support (DSMES) and Medical Nutrition Therapy (MNT) are the core functions of the Center in which participants learn to live successfully with diabetes through guidance from our dedicated physician, certified diabetes educators, nurses, dietitians, and clinical social worker. In CY18, there were over 1443 patient encounters. A subset of 322 patients receiving DSMES services were offered access to a social worker to provide

additional clinical support related to psychosocial barriers which are impeding healthier lifestyle choices at no cost to patients as part of DSMES.

Ueberroth Family Program for Women with Diabetes (Sweet Success)
Expectant mothers with diabetes prior to pregnancy and those diagnosed with gestational diabetes, who are at higher risk of developing Type 2 diabetes after pregnancy, benefit from pre-conception family planning, diabetes education, as well as ante-partum and post-partum glucose management. In CY18, we had a total of 2,016 encounters completed at the Center. The Center offers free oral glucose tolerance testing (OGTT) 4-12 weeks postpartum. In 2018, 216 patients came to receive their OGTT at the Center.

Annual Diabetes Nursing Conference
The Annual Diabetes Conference titled "Diabetes: What's new? What's next?" was held on October 27th, 2018. There were 125 attendees which included physicians, nurses, dietitians, certified diabetes educators and social workers. This one-day conference provided information on diabetes management and topics that included emerging adults with type 1 diabetes, diabetes care during pregnancy, multidisciplinary approaches to care for patients with type 2 diabetes, diabetes and cardiovascular disease, and approaches to treatment of pre-diabetes.

CHOC Children's Services at the Allen Diabetes Center
Children's Hospital of Orange County (CHOC) Diabetes and Endocrine Center at the Allen Diabetes Center provides pediatric specialty care services for patients with diabetes. This program provides clinical services, health maintenance and treatment, and outreach for children considered at risk for developing diabetes. In CY18, there were more than 1200 clinical encounters. Prevention of Obesity and Diabetes through Education Resources (PODER) offers no-cost diabetes and obesity prevention education programs, cooking classes and Zumba exercise classes. PADRE (Pediatric Adolescent Diabetes Research Education Foundation) provides support to children with Type 1 diabetes and to their families through events and educational workshops. Approximately 1400 participants joined the PODER classes, and 267 participants were involved in the PADRE classes.

Herbert Family Program for Young Adults with Type 1 Diabetes
The Herbert Family Program focuses on catering to the unique needs of young adults with Type 1 Diabetes (ages 18-30). The program addresses various aspects including the financial, psychological, social and physical changes that challenge the young adult, their family, and support systems. We hosted First Fridays with a consistent attendance of 10-15 emerging adults in which these are held monthly.

Outreach Events
Approximately 850 people participated in the Sweet Life cooking classes. During these classes, an educator and Hoag's Executive Chef provided insight on recipes and nutrition to promote healthy eating for our community. Our educators have participated in various outreach opportunities including the following: health fairs, presentations at senior centers, risk assessment tests, grocery store tours, and cooking demonstrations.

Contact: Denise Koslicki, MHA at 949-764-8065 or Denise.Koslicki@hoag.org

OB Education

Hoag's philosophy is that with the birth of every child, there is also the birth of a new family. Through a variety of educational classes and support services. Hoag's OB Education department supports families throughout the exciting journey of pregnancy and parenthood. Board certified registered nurse lactation consultants, support new couples and their infants in breastfeeding following delivery in the hospital and in the out-patient breastfeeding clinic. We provide in-hospital breastfeeding consultations 365 days per year, and outpatient consultations Monday through Friday 9am to 4pm. Our nurses also teach a comprehensive selection of prenatal classes including: Prepared Childbirth, Breastfeeding Baby Care Basics, Pre-Birth Boot, Camp Baby Saver infant first aid and CPR, and Multiple Miracles, which is a class for couples expecting twins, triplets, quadruplets and more. OB Education has partnered with the Hoag Center for Wellness to promote pelvic health and maternal mental health through the post-partum period. The pelvic floor care class is taught by a licensed physical therapist that is specially trained in female pelvic floor issues. Several other programs are offered at no cost to the community and include car seat safety, couples 4th Trimester class, hospital orientation and online breastfeeding education.

Hoag's Community Benefit program promotes community mental health through support of a weekly Post-Partum Adjustment and Perinatal Loss group and a biweekly Pregnancy after Loss group. These groups are lead and facilitated by a licensed clinical social worker whose professional fees are funded by the Community Benefit program. In 2018, the groups provided services to ___postpartum women reflecting a ___ increase from 2017 and are offered at no cost to the community. They provide ongoing support, education, and a safe setting to discuss the new challenges of parenthood. Support persons and babies are welcome. In addition, the Community Benefit program provides breastfeeding supplies for women that are cared for in OB Education's out-patient breastfeeding clinic.

Hoag's BabyLine is an information telephone hotline for new parents that operates five days a week and is answered by an OB Education registered nurse with expertise in pregnancy, newborn care and breastfeeding. The BabyLine staff is a key resource for new and expectant parents. The phone line is available to the community Monday through Friday from 9:00am – 5:00pm and received over 15,000 calls in FY 2018.

Summary of Classes and Services provided by the OB Education Department in FY2018

Class	Attendance
Baby Care	1010
Baby Saver	1160
Breastfeeding	745
Car Seat Safety	824
4th Trimester	102
Maternity Orientation	2361
Multiple Miracles *(offered quarterly)*	36
Prepared Childbirth	1217
Pre-Birth Boot Camp for Couples *(new class offered 2 times)*	144
Breastfeeding Clinic Visits *(outpatient)*	1,200
Baby Line telephone calls	15,105
Postpartum Support Groups: Postpartum Adjustment, Perinatal Loss, & Pregnancy after Loss Groups *(funded by community benefit)*	478

Contact: Sheryl Wooldridge at 949-764-5951 Sheryl.Wooldridge@hoag.org

CHAPTER V: HOAG COMMUNITY HEALTH ASSOCIATES

Share Our Selves Corporation

Share Our Selves Corporation (SOS) is a Coordinated Care Agency with 49 year history of providing comprehensive care and safety-net services to low-income, homeless, and marginalized individuals and families living in Orange County. The commitment of SOS to the integration of health and social services for the most at-risk populations in our community has remained steadfast since 1970. SOS and Hoag alignment of mission, through the Community Benefit Program, has provided funding for patients without access to care an avenue to health and well- being.

Generous grant funding from the Hoag Community Benefit Program during the 2018 calendar year has been able to provide:

- **3,536** unduplicated uninsured individuals personalized care
- **9,544** medical encounters at the SOS Community Health Center in Costa Mesa
- A **reduced utilization of Emergency Department** due to access for medical care at SOS
- An **increased access** to primary care allowing for timely, efficient, and quality health care for those in need
- A **$25,000 event sponsorship** for SOS events

This long-standing relationship between SOS and Hoag has ensured primary care services for the most vulnerable with strategic goals that work to improve the overall well-being of our shared community.

The SOS clinical network is a Federally Qualified Health Center with special designation as a Healthcare for the Homeless provider. SOS centers of care are nationally recognized as a Patient Centered Medical Home by the National Committee for Quality Assurance. Consisting of 6 service sites throughout Orange County, SOS has been able to provide primary medical, dental, and mental health care in a timely, efficient, quality, and personalized manner. Patient care remains complimented by our comprehensive Social Services program, which provides direct access to extensive support and safety-net services which address the social determinates of health. These services include, but are not limited to, the SOS Food Pantry, SOS Center of Care for the Homeless, Emergency Financial Aid, Case Management, and an array of special seasonal programs including the annual SOS Back to School program and SOS Adopt A Family program. The Social Service Department serves over 100,000 unduplicated low-income and/or homeless county residents through direct services and referrals. This extensive array of services are not restricted to patients only but open to all residents of Orange County.

Hoag's Community Benefit grant of one year supports access to primary care for the uncompensated and is vital to the wellbeing of our local community and the sustainability of SOS. This grant supports access to urgent and primary care at the right time necessary for patient healing.

For more information regarding Share Our Selves www.shareourselves.org

Alzheimer's Family Center

Alzheimer's Family Center (AFC) has applied general operating funds generously contributed by Hoag Memorial Hospital Presbyterian to continue meeting the increased demand for high-quality dementia-specific adult day services for Orange County's most medically and financially vulnerable seniors. Across the reporting timeframe of January 1, 2018 to December 31, 2018, we have been able to achieve the following with the support of Hoag Hospital:

(1) We have provided 26,393 cumulative patient days for 306 unduplicated adult day health care patients, and 167 cumulative patient days of Saturday care (social model) for 14 of our patients.

(2) Our case managers have fielded 321 inquiries from families community-wide seeking to access supportive services (e.g., adult day health care, caregiver support groups) for themselves and their memory impaired loved ones. Approximately 38% of the families who inquire about our services admit their loved one into our adult day health care program. Each prospective patient is screened to assess whether our adult day healthcare programs may be beneficial or whether a higher level of care is required.

(3) Our average daily attendance (ADA) or average daily census for the reporting period was 118. We had 123 new patient admissions and 97 patient discharges for an attrition rate of 4.25% Patient discharges were mainly attributable to patient health decline or placement into higher levels of care.

We would like to share some demographics and characteristics of our patient population:

- Average patient age is 74.5.
- 87% of our patients have 2 or more chronic medical conditions in addition to dementia.
- 52% of our patients use an assistive device for ambulation.
- 44% of our patients require a special diet (e.g., diabetic, pureed, mechanical, chopped).
- 94% of our patients have behavioral symptoms (e.g., wandering, agitation, aggression).
- 68% of our patients are identified as high risk for falls.
- Race/Ethnicity:
    - 72% White
    - 19% Asian
    - 7% Hispanic/Latino
    - 1% African American
    - 1% Other
- 46% of patients are male; 54% are female.
- We serve patients from 33 cities.

Additional Updates Across Reporting Period

Nursing Care - Our nursing department made 456 new and recurrent assessments, and our staff made 2,804 contacts to family caregivers to address medical needs such as foot checks, medications, TB tests, first aid, illness and bathroom issues. In addition, staff made 462 contacts with patients' primary care physicians to address medical needs (i.e., diabetic foot checks, blood sugar readings that were out of range, pain management, medication adjustments).

Intensive Outpatient Program – Intensive Outpatient Program – Alzheimer's Family Center, in partnership with Mission Hospital, launched the Mind & Memory Program in January 2018. The Mind and Memory Program is an Intensive Outpatient Program serving individuals with both a cognitive disorder and a psychiatric disorder such as depression, anxiety, post-traumatic stress disorder and more. In the first year of operation, the Mind and Memory Program served more than 100 patients and provided 3,026 days of service, operating both morning and afternoon programs Monday through Friday. Sixty-seven percent of patients in the program have shown a decrease in depressive symptoms, 52% have showed an improvement in cognition, and 43% of patients showed a decrease in anxiety symptoms since starting the program.

Mission Moment
During the reporting period, we admitted Maria D., who started in March 2018. When Maria started attending Alzheimer's Family Center, she was extremely anxious and often would make suicidal statements. Her anxiety caused her to slap herself in the face and she even asked for a gun a few times. Her daughter and primary caregiver shared that she was very difficult to manage at home and was causing a lot of trouble. However, we started seeing changes in her behavior within the first two to three months of attending Alzheimer's Family Center. Our team is providing constant reassurance and keeping her very busy—they encourage her to engage in simple activities such as folding linen, sticking stamps, or walking around the building. She also truly enjoys daily music therapy, which has diminished her anxiety greatly. Over the first six months of attending, Maria's Mini-Mental State Examination (MME) went up 2 points and has now completely stopped making suicidal statements.

Contact: Joanna Richardson-Jones, CEO at (714) 593-1840 or JRichardsjones@AFCenter.org

Costa Mesa Family Resource Center

The Costa Mesa Family Resource Center (CM FRC) is a family friendly community based collaborative with the capacity to provide on-site access to comprehensive prevention, intervention, and treatment services. As one of 15 Family Resource Centers throughout Orange County, the Costa Mesa FRC provides social, educational, health, and supportive services for all families including birth, blended, kinship, adoptive, and foster families. Services are culturally sensitive and offered by staff in the language reflecting the families and communities served. The Costa Mesa FRC serves as a vehicle for engaging local residents and community organizations by actively seeking and promoting leadership of community members through partnership with Community Engagement Advisory Councils (CEAC's). Families walking into the Costa Mesa FRC can access a menu of "Core Services," which have been designed based on best practices. These Core Services include:

- Counseling
- Parenting Education
- Family Support Services
- Domestic Violence Personal Empowerment Program
- Information and Referral Services
- Comprehensive Case Management Services
- Out of School Time Youth Programs
- Family Reunification Family Fun Activities
- Adoption and Promotion Services

The collaboration with Hoag has strengthened the CMFRC in providing additional community resources and network of supports and services. Located in Hoag's Center for Healthy Living, the Costa Mesa FRC is able to provide families with access to a broad range of comprehensive services. Below are some highlights from January 1, 2018 – December 31, 2018. The collaborative partners that help the CMFRC to provide these services include: Human Options, Girls Inc., Raise Foundation, and Children's Bureau. Additional collaborations have also included Moms of Orange County, Help Me Grow, Newport Mesa Unified School District and Second Harvest Food Program. This last fiscal year, CMFRC has added the Strong Families Strong Children collaborative, Community Action Partnership of Orange County and Art for Healing, as other nonfunded partners. CMFRC has recently been collaborating with the City of Costa Mesa on various projects to better support the community. This reporting period, CMFRC has over 6,500 encounters with the children and families in the Newport Mesa community. This includes walk-ins, referrals, accessing services and/or attending events. With CMFRC completing its 4th year since opening its doors, there has been significant growth in children and families served and linkage to services.

Teen Conference - This year marked the 3rd Annual Love Shouldn't Hurt: Teen and Parent Conference. The conference was dedicated to promoting awareness about Healthy Relationships while increasing communication between teens and parents or caring adults. The day included an engaging day of workshops for both teens and parents/caring adults, a community resource fair

with 10 local agencies sharing about services and resources, and activities for younger siblings. The event was hosted at Costa Mesa High School, with over 75 participants attending the event. The event was an overall success.

Food Distributions - at CMFRC have been a tremendous support to families not only from the Newport and Costa Mesa areas, but through all of Orange County. On average, there are about 150 families served each month, with our highest serving 212 families. The food distribution is a collaboration between the, CMFRC, Melinda Hoag Smith Center for Healthy Living, and Second Harvest Food Bank. The distributions are led by staff and community volunteers who donate their time and support. Since the last reporting period, there has been an increase in volunteers who have committed their time to giving back to the community through the food distributions. Some of the volunteers come from groups including the Key Club, Hoagnar team, and Assistance League, and teachers from the school district. Food distributions are held the 1st Saturday of the month (excluding holidays) at 1pm. Another highlight through this service has been the number of children attending. On average, there are 50 children served during the food distributions who require childcare while families receive their food. Thus, Girls Inc. staff and Human Options Children's Activity leaders plan intentional activities for the children during these events.

Out of School Program **-** This last 2018-2019 fiscal year, demonstrated the continued need for after school programming for youth, specifically during the summer. To meet the needs of the community, Costa Mesa FRC in partnership with Hoag hosted a summer camp for elementary aged children in the Costa Mesa community for its second year. There were over 85 children ages 5 to 11 who were served through the summer camps ranging from existing to new families. The staff were able to provide various programming while maintaining a fun learning environment. Such examples include bringing a reptile zoo, outdoor activities at the park, literacy with dogs, and more. This service continues to demonstrate its need and success in the community, while continuing to exceed the contractual goals set by OC SSA's FaCT program.

Case Management Team Meetings - One of the services provided by the Costa Mesa FRC includes the comprehensive case management team meetings. It is an integrated multidisciplinary team comprised of professionals. The purpose of these meetings are to identify the educational, health, or social services needs of child and child's family; and for developing a plan to address meeting those needs. Through increased partnerships with the Newport Mesa School District and other collaborating partners, the CMT meetings have grown to include over 10 different agencies represented, including SSA liaisons, SPIN housing specialist, Big Brothers Big Sisters and more. The addition of these partners to this meeting has enhanced the level of support and expertise of the meetings for the families in need of services.

Contact: Arezoo Shahbazi, MSW 949-764-8100 Ext. 53693 or
ashahbazi@humanoptions.org

Latino Health Access

The mission of Latino Health Access (LHA) is to partner with communities to bring health, equity and sustainable change through education, services, consciousness-raising and civic participation. In 2018, it celebrated its 25-year presence in low-income communities. LHA operates highly-effective and culturally- and linguistically-competent services in these communities, all facilitated by Promotores, Community Health Workers trained from the same communities in which our programs operate. These programs and services, broadly include:

- Outreach—using culturally-relevant symbols as an entry-point to engage local residents, Promotores conduct one-on-one outreach to distribute key messaging around health prevention, program offerings, or available resources in the community.
- Chronic Disease Prevention—from exercise classes to structured obesity remediation services to workshops on reduction of stress, Promotores focus on helping participants to modify behaviors and address structural challenges that will result in health improvement and reduction of risk of chronic disease.
- Chronic Disease Management—structured programming aimed at addressing barriers to disease management. These programs have included rigorous and clinical outcomes that often surpass the outcomes of clinic-based programs.
- Peer-led Emotional Wellness Services—using narrative therapy and trauma-informed approaches, Promotores facilitate one-on-one, group, and family structured emotional wellness sessions to help individuals and families to improve their overall coping mechanisms and quality of life.
- Civic Engagement and Advocacy—ongoing leadership development and engagement of residents as partners in addressing policy, systems and environmental changes in their community

In FY 2018, Hoag Community Benefit contributed to Latino Health Access' *Women and Children's Chronic Preventive Services*. Through this initiative, LHA Promotores conducted 88,996 outreach contacts, providing health prevention and promotion messages to more than 35,500 women and children. Additionally, through a range of prevention activities, 2,814 unduplicated women and children lowered their risk of developing a chronic disease, and 2,192 of them demonstrated taking at least two steps to prevent or manage chronic disease. Lastly, Promotores provided referrals to participants that resulted in 612 links to service.

LHA also implemented its Promotor-facilitated *Diabetes Self-Management Program* with support from the Hoag Community Benefit. 204 unduplicated participants with a diabetes or pre-diabetes diagnosis graduated from the 12-week self-management educational sessions using an equity lens. Among a subset of these participants (n=119), 83.2% managed to lower or maintain their baseline Hemoglobin A1c. Additionally, LHA Promotores made 380 referrals to appropriate healthcare providers for diabetes-related services, including but not limited to nutrition, podiatry, ophthalmology, and general medicine. Promotor follow-up and assistance resulted in a 91.5% service linkage. Additionally, 8 participants who faced significant challenges

to diabetes self-management at the end of their program participation received a combined 41 units of additional services, after which 100% were able to manage their diabetes.

These programs are uniquely tailored to address the social determinants of health that create health disparities in low-income communities. LHA Promotores are especially effective in engaging participants to take a central role in their health and well-being.

Contact: Francisca Leal, at 714-542-7792 Ext. 1022 or fleal@latinohealthaccess.org

Newport-Mesa Unified School District – HOPE Clinic

The HOPE Clinic is a school-based health center within the Newport-Mesa Unified School District. Health promotion, immunizations, and well-child exams are the cornerstone of the program. The HOPE Clinic is a program of Health Services and participates in the Child Health and Disability Prevention Program and the Vaccines for Children Program. It is one of 286 school health centers in the State.

The primary focus of the clinic is to help children meet school entry requirements, promote health through periodic well-child exams and routine immunizations, and provide early interventions to health problems. Services are at no cost to families and provided by a bilingual Spanish-speaking staff. Other services include Tuberculosis screening and testing for students, staff and school volunteers. The clinic also does developmental screening, vision and hearing screenings, dental screening and fluoride application for students. The clinic makes referrals and connects students and their families to resources in the community. The clinic staff are district employees and are familiar with district services and school requirements. One of the clinic's strengths is that the staff knows school requirements and is able to assist families in meeting those requirements for school participation.

The HOPE Clinic is unique in that it is a school-based health center located in a community school setting. It is housed on a campus with an elementary school, district run preschool, a Head Start Program, an adult education center, two after school programs including the Boys and Girls Club and Save Our Youth (SOY), and the community theatre. The HOPE Clinic is staffed with Nurse Practitioners, a supervising physician, an Office Assistant, and Health Assistant. The nurse practitioners are school nurses. They serve not only as medical providers in the clinic but also as nurses assigned at school sites. The nurse practitioners are experts in school health and highly knowledgeable about school programs. This makes them a trusted and invaluable resource for students and families.

During 2018, the clinic had 2,282 patient encounters. Five hundred and one (501) physical exams were performed. The clinic received 597 pediatric visits for immunizations and 1200 adult visits for immunizations. The adults served were mostly parent volunteers at the schools or they are staff. The HOPE Clinic hosted 7 Flu Vaccine Clinics open to anyone in the community at no

charge. Patient education and anticipatory guidance were provided during every patient encounter. Six hundred and ninety-five (695) referrals were made for services including dental, vision, hearing, mental health, speech, and medical. Six hundred thirty-seven children (637) were qualified for insurance which typically occurred the day of the clinic visit.

HOPE Clinic works collaboratively with other community providers to tailor services to address community needs. The Children's Health Initiative of Orange County provides an insurance application assistant one day per week. Dr. Riba is a physician specializing in obesity and nutrition. She and her team of specialists have worked with the HOPE Clinic for nine years addressing nutrition and obesity. The Reach Out and Read Program provides books for our younger patients. The HOPE Clinic also utilizes the state immunization registry program called CAIR to make it easier for families to store protected but accessible immunization information. HOPE Clinic also supports the District Welcome Center as it enrolls new students into the District for the first time. HOPE Clinic reviews immunization and determines if students meet the health requirements along with providing needed services.

Contact: Merry Grasska, at 949-515-6730 Ext. 1022 or mgrasska@nmusd.us

Orange County Human Relations

BRIDGES Safe and Respectful Schools Program and Walk In My Shoes Youth Conferences

At OC Human Relations, we believe that all people have the right to live free from discrimination and violence. We have a **mission** to foster mutual understanding among residents and eliminate prejudice, intolerance and discrimination in order to make Orange County a better place for ALL people to live, work, go to school and do business.

All of OC Human Relations' programs were created to address inequities and imbalances impacting those in our community who are marginalized by bigotry and intolerance. Founded as a non-profit in 1991, OC Human Relations is a nationally-recognized leader in creating safe, inclusive schools and communities, developing and empowering diverse leaders, mediating conflict, and building respect and inclusion among all people.

Unfortunately, bullying, harassment and student violence have increased on our school campuses and have become increasingly serious issues for our students. These issues contribute to interpersonal and intergroup tensions both on and off campus. Students who are harassed or are instilled with fear at school frequently suffer long-term social, emotional and psychological harm. The most effective way to reduce this harm is to create a school-wide culture of inclusion and respect for differences where students feel connected and safe, both physically and emotionally.

OC Human Relations' comprehensive anti-bullying BRIDGES Safe and Respectful Schools Program develops diverse student leaders who work to create positive school climates where all

students feel welcomed and can succeed. Throughout the school year, students and their adult allies participate in training and workshops that provide them with the skills, knowledge and tools to address human relations issues on their campus such as bullying, prejudice and harassment and become the role models who create positive change and stand up for fairness and respectful treatment for everyone.

The BRIDGES Program also now includes a Restorative Schools Program which provides a positive alternative to the traditional school disciplinary practices of suspension and expulsion, helping to keep students in school instead of pushing them out, which disproportionately impacts students of color, those with disabilities and LGBTQ students, who are suspended and expelled at much higher rates than their white counterparts.
In addition, our extremely popular Annual Walk In My Shoes Youth Conferences bring together more than 1,000 middle and high school students and teachers to explore issues of identity and culture, develop an understanding of current human relations issues, develop their leadership skills, and empower students to create positive social change on their campuses and in their communities.

During the 2017-18 academic year, BRIDGES programs were provided in 16 middle and high schools serving a majority of low-income, underserved and at-risk students in Orange County. More than 30,800 students, staff, administrators, parents and community members were engaged in creating safe, inclusive, supportive and respectful school climates that promote social and academic success as well as creating a sense of belonging and social connectedness that promotes healthy outcomes for all students.

Walk In My Shoes (WIMS) Youth Leadership Conferences are held twice a year: one for high school students at Cal State Fullerton, and one for middle school students at UC Irvine. Registration for WIMS Conferences always reaches capacity within a few hours of announcing that it is open. During the 2017-18 academic year, more than 1,100 students and teachers were introduced to human relations issues, performances, speakers and interactive workshops encouraging students and educators to make a positive difference in their schools and communities.

All of these programs focus on engaging youth in leadership development with an emphasis on developing their understanding of how human relations issues impact students, schools and communities and what they can do to foster and create equitable, respectful and welcoming environments for everyone.

Hoag's investment in these programs as a long-time partner with OC Human Relations has enabled us to serve more than 30,000 students annually and allowed up to expand our Walk In My Shoes Conferences to two per year with more age-appropriate programming for middle and high school students.

Research shows that students learn best in a safe, respectful and inclusive environment. These unique programs address the harms of stereotyping, the debilitating results of intolerance and the dehumanization that occurs when students or teachers make judgments based on pre-conceived

beliefs and fears, and how that leads to bullying, harassment, violence, exclusion and lowered performance expectations.

The students' worlds grow larger as they are exposed to and work together with different people from different backgrounds, cultures and experiences, helping to prepare them for higher education and a diverse work force. They also gain the life skills that equip them to approach challenges in a positive and fair-minded way.

Contact: Alison Edwards, CEO at 714-480-6570 or Alison@ochumanrelations.org.

Appendices

Appendix A Hoag Hospital Charity Care and Self Pay Discount Policy

Appendix B Hoag Hospital Quantifiable Community Benefit for CY2018

Appendix C Hoag Hospital Community Benefit Expenditures by Program

APPENDIX A

Policy

Category: REVENUE CYCLE	Effective Date: See footer
Owner: Executive Director, Revenue Cycle	
Title: Financial Assistance Policy	

PURPOSE: This policy outlines Hoag Memorial Hospital Presbyterian's operational guidelines on the Financial Assistance Program (FAP) in relation to the patient collections process.

SCOPE: Revenue Cycle

AUTHORIZED PERSONNEL: Charity Care Coordinator, Self-Pay Manager, Self-Pay Supervisor, Collectors, Financial Councilors, PAS Supervisors, Insured and Uninsured Patients

Description

Contents

Financial Assistance Policy

Policy	Hoag seeks to address patient's health care and financial needs while remaining committed to the stewardship of Hoag resources. To ensure that Hoag obtains appropriate reimbursement for services provided, several payment options and programs are available to support the needs of uninsured and underinsured patients. When it is determined that a payment solution cannot be obtained through such payment options and programs, then the patient is provided with information about the Hoag Financial Assistance Program (FAP). Patient collections processes shall remain in compliance with Hoag policies relevant to patient financial assistance: ■ Any patient who requests financial assistance will be afforded the opportunity to

	apply and be considered. ■ Access to necessary care shall in no way be affected by whether financial assistance eligibility exists; medically necessary care will always be provided to the extent the Hospital can reasonably do so. ■ The need for financial assistance is a sensitive and deeply personal issue for patients. All Hoag employees will maintain confidentiality of requests for assistance, the information obtained in the application process, and the funding or denial of assistance. ■ In an effort to ensure patients' post-acute and follow-up health care needs are met, patients who demonstrate lack of financial coverage by third-party insurance are offered information on how the patient may obtain applications for Medicare, Medicaid, Medi-Cal and the Healthy Families Program (CA), coverage offered through the Covered California (CA), or other state or county funded health coverage programs. Hoag will assist patients with applying for government-sponsored programs and follow through to acceptance or denial.

Patient Collections

Collections Process Overview

It is the expectation that the patient's estimated cost or liability will be collected in full prior to or at the time of service. If a patient states they cannot pay in full, payment options and programs are offered during the collections process in a consistent sequential order as outlined below:

Stage	Description
1	Full payment is requested.
2	A reasonable payment plan based on the estimate is offered. A deposit payment is requested, if appropriate.
3	Eligibility for Government-Funded Programs is explored in programs including , but not limited to: ■ Medicare ■ Medi-Cal (CA) ■ Covered California ■ other state or county funded health coverage programs
4	When a payment solution cannot be found in Stages 1-3, then the patient is provided with information about the Hoag Financial Assistance Program (FAP). Pending applications for coverage through FAP and from a government funded health program will not preclude the patient's eligibility for eligibility for the other program.

Policy

Category: REVENUE CYCLE	Effective Date: See footer
Owner: Executive Director, Revenue Cycle	
Title: Financial Assistance Policy	

		Important: If at any time, patient requests information or an application for Hoag Financial Assistance, it is promptly provided to the patient.

Financial Assistance Program

Overview	Hoag Financial Assistance Program (FAP) ensures that medically necessary health care is provided at discounted or no cost to qualified uninsured and underinsured patients. Any uninsured or underinsured patient who is unable to pay his or her Hospital bill and whose income meets the approved federal poverty level (FPL) qualifications will be considered eligible for Hoag Financial Assistance (FA). Additionally, patients who incur qualified High Medical Costs may be deemed eligible for financial assistance. Hoag Hospitals serve all persons in the communities where we are located. We aspire to provide health services with the upmost dignity and compassion for each patient and family in our care. In a confidential and caring environment patients in need are provided financial assistance to pay their Hoag Hospital bills and, in turn, to ensure access to needed healthcare as an essential element of fulfilling their human dignity and ability to live more healed, more whole, and more able to contribute to the common good.
Completion of FAP Application	Upon a patient's request, a Financial Assistance Program (FAP) application shall be provided. Designated personnel will assist patients in completing the Financial Assistance Application and determining eligibility for financial assistance, charity care, or government-funded programs, if applicable. Financial Assistance notices printed in English and Spanish are also placed in the public admission areas at Hoag hospitals. Interpretation services are available to address any questions or concerns and to assist in the completion of Financial Assistance Applications. A patient, or patient's legal representative, who requests a discounted payment, charity care, or other assistance in meeting his or her financial obligation to the hospital shall make every reasonable effort to provide the hospital with documentation of income and health benefits coverage. If the person requests charity care or a discounted payment and fails to provide information that is reasonable and necessary for the hospital to make a determination, the hospital may consider that failure in making its determination. Upon establishing full or partial eligibility under the financial assistance program the

	coverage will be valid for six (6) months from the date of the eligibility letter. Additionally, other pre-existing patient account outstanding balances at the time of eligibility determination will be included as eligible, excluding exceptions set forth in this policy.
Patient Billing	Patients applying for Hoag Financial Assistance will continue to receive monthly statements as an awareness of the open balance and to encourage patient engagement if needed. Statements mailed to the patient will include a clear and conspicuous notice advising the patient of Hoag Financial Assistance Program and the appropriate contact information. The notice shall also: a. advise the patient that he or she may be eligible for programs such as Medicare, Medi-Cal(CA), Covered California or other state or county funded health coverage programs b. how the patient may apply for any of these programs and that the Hospital will provide the patient with an application.(CA) c. that the Hospital will refer the patient to a local consumer assistance center housed at legal services offices.(CA) Disputes: Efforts to collect healthcare debts by an affiliate, subsidiary or external collection agency of Hoag must adhere to the standards set forth in this policy including the definition and application of a reasonable payment plan. In dealing with patients eligible for Hoag Financial Assistance or a reasonable payment plan, the Hospital shall not use wage garnishments or place liens on homes as a means of collecting unpaid Hospital bills. This requirement does not preclude Hospitals from pursuing reimbursement from third party liability settlements. Accounts without an existing FAP or payment arrangement will transfer to an external collection agency at 150 days from first patient billing cycle. Accounts with a defaulted payment plan with three consecutive missed payments will transfer to an external collection agency upon review and approval of the department supervisor to ensure reasonable attempts to reach the patient/guarantor were made.
Proof of Income	The patient will submit all necessary income documentation, including copies of IRS forms, W-2 Wages & Earnings, disability payment statements, etc. An application for a government program (i.e., prescription drug assistance programs, DHS, SSI, or any

	other signed federal program document), may be used to qualify for financial assistance. Financial information obtained will not be used to determine collection activities. In cases where documentation is unavailable, the patient's income may be verified by having the patient sign the assistance application attesting to the veracity to the income information provide. If the proof of income is questionable, validation of the income should be immediately requested.

Income Qualifications – CA Hospitals

Any uninsured or underinsured patient whose family income is less than 400% of the current federal poverty level (FPL) and is unable to pay his or her Hospital bill shall be considered eligible for financial assistance. Full or partial assistance is based on the criteria outlined below:

<table>
<tr><th>If the income % of FLP is:</th><th>And the patient is:</th><th>Then:</th></tr>
<tr><td>200% or less,</td><td>Uninsured or insured</td><td>The entire (100%) patient liability portion of the bill for services will be written off.</td></tr>
<tr><td rowspan="2">201% - 400%,</td><td>Uninsured,</td><td>The patients' payment obligation will be a percentage of the gross amount the Medicare program would have paid for the service based on the sliding scale below:
<table>
<tr><th>If the income % of FPL is:</th><th>Then the % of Medicare LIKE Rate Payable is:</th></tr>
<tr><td>201 – 400%</td><td>50%</td></tr>
</table></td></tr>
<tr><td>Insured,</td><td>The patient's obligation will be reduced by insurance payments:
<table>
<tr><th>If:</th><th>Then:</th></tr>
<tr><td>The amount paid by insurance exceeds what Medicare would have paid,</td><td>The entire (100%) patient liability portion of the bill will be written off.</td></tr>
<tr><td>The Medicare Payment LIKE Rate is greater than the HMO/PPO Payment Rate for services rendered,</td><td>The patient's payment obligation will be based on the HMO/PPO Payment Rate.</td></tr>
</table></td></tr>
<tr><td>201% - 400%,</td><td>Insured, yet services are not covered by the payer,</td><td>The following will apply:
<table>
<tr><th>If...</th><th>Then ...</th></tr>
<tr><td>The patient ordinarily would be responsible for the full billed charges,</td><td>The total patient payment obligation will be the HMO/PPO Payment Rate.</td></tr>
</table></td></tr>
<tr><td>201% - 400%,</td><td>Insured, and services are covered by the payer,</td><td>The following will apply:
<table>
<tr><th>If:</th><th>Then:</th></tr>
<tr><td>The patient is responsible for only a portion of the billed charges (deductible, copay, etc.),</td><td>There is no discount.</td></tr>
</table></td></tr>
</table>

Automatic Classification for Charity Care

Under the following special circumstances, a patient may be deemed eligible for Charity Care without absolute requirement for submission of a financial assistance application:

Circumstance	CALIFORNIA
Eligible for other FPL-qualified programs	(Addressed in Other Special Circumstances section below)
Disabled	n/a
Deceased	Is deceased and without third-party insurance coverage or identifiable estate, no living spouse
Incarcerated	n/a
Homeless	Is determined to be homeless and is not currently enrolled in Medicare, Medicaid or any government sponsored program, without third-party insurance coverage
Seen in ER, unable to bill	Is treated in the Emergency Department but the Hospital is unable to issue a billing statement
Access to Care	Is treated through an Access to Care Program

Other Special Circumstances	Patients who are eligible for FPL-qualified programs such as Medi-Cal, Medicaid , and other government-sponsored low-income assistance programs, are deemed to be indigent. Therefore, such patients are eligible for Charity Care when payment for services is not made by the programs. Patient account balances resulting from non-reimbursed charges are eligible for full charity write-off. Medi-Cal Share of Cost obligations are not eligible for charity write off or the discount program. Specifically included as eligible are charges related to the following: ■ Denied inpatient stays ■ Denied inpatient days of care ■ Non-covered services ■ Treatment Authorization Request (TAR) denials ■ Denials due to restricted coverage

Category: REVENUE CYCLE	Effective Date: See footer
Owner: Executive Director, Revenue Cycle	
Title: Financial Assistance Policy	

Presumptive Charity	Hoag recognizes that a portion of the uninsured or underinsured patient population may not engage in the traditional financial assistance application process. If the required information is not provided by the patient, Hoag utilizes an automated, predictive scoring tool to qualify patients for Charity Care. The PARO™ tool predicts the likelihood of a patient to qualify for Charity Care based on publicly available data sources. PARO provides estimates of the patient's likely socio-economic standing, as well as, the patient's household income and size.
Approval Levels	Financial assistance determination will be made only by approved Hospital personnel according to the local Hospital levels of authority. **Notification of Determination** Patients will receive notification of Hospital determination within 30 days of submitting the completed application and supporting documentation. **Patient Disputes** FAP qualifications are determined after the application is reviewed for eligibility based on criteria contained in this policy. Financial assistance shall not be provided on a discriminatory or arbitrary basis, however the hospital retains full discretion to establish eligibility criteria based on sufficient evidence and information provided by the patient or guarantor. In the event of a dispute, a patient or guarantor may seek review from management or the executive director of revenue cycle via email at PFS@hoag.org or in writing by providing additional information to support the dispute at: Hoag Memorial Hospital Presbyterian Attn: Executive Director of Revenue Cycle 500 Superior, Suite 250 Newport Beach, CA 92663
Proof of insurance	If a hospital bills a patient who has not provided proof of coverage by a third party at the time the care is provided or upon discharge Hoag will provide the patient with a Notice Of Availability Financial Assistance (NAFA)

Category: REVENUE CYCLE	Effective Date: See footer
Owner: Executive Director, Revenue Cycle	
Title: Financial Assistance Policy	

Definitions

This publication contains the following terms:

Term	Definition
Affordable Care Act (ACA)	A federal mandate that aims to increase the quality and affordability of health insurance.
Charity Care	Medically necessary Hospital services provided at no cost to a patient who lacks or has inadequate insurance and meets defined low-income requirements.
Covered California	California's Health Insurance Marketplace program that provides assistance in shopping for affordable health care and possibly financial assistance. Covered California will also assist in determining qualification for Medi-Cal.
Deposit	When payment arrangements are made, the first installment payment is considered the deposit. The deposit is negotiated, starting at 50% of total estimated patient liability.
Government-Funded Insurance Programs	The following are included in "government-funded insurance programs" (but is not limited to): ■ Medicare ■ Presumptive Eligibility (Medi-Cal) ■ Medi-Cal (CA) ■ Covered California (CA) ■ Out Of State Medicaid
Health Insurance Marketplace	A component of the Affordable Care Act (ACA) is the Health Insurance Marketplace (formerly known as Exchange). Each state is mandated to have this on-line venue for consumers and small businesses to compare and purchase insurance coverage options and to learn if they are eligible for federal insurance subsidies.
High Medical Costs	California: A patient is considered to have High Medical Costs if he or she has either of the following: ■ Annual out-of-pocket costs incurred by the individual at the Hospital that exceed 10 percent of the patient's family income in the prior 12 months. ■ Annual out-of-pocket expenses that exceed 10 percent of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.
HMO/PPO Payment Rate	The average amount of payment the Hospital would receive from all contracted HMOs/PPOs for providing services. This rate, represented as a percent of total billed charges, is Hospital-specific and updated periodically.
Out of State Medicaid	Hoag will bill for Out of State Medicaid provided a contract is approved by the state and/or obtained through an outsourced vendor.

Category: REVENUE CYCLE	Effective Date: See footer
Owner: Executive Director, Revenue Cycle	
Title: Financial Assistance Policy	

Term	Definition
Medi-Cal (CA)	Medi-Cal is California's federally funded health insurance programs that pays for a variety of medical services for children and adults who have limited resources and low-income. Under ACA, Medi-Cal has expanded who may be eligible.
Medically Necessary Services	Services or supplies determined to be proper and needed for the diagnosis, direct care or treatment of the medical condition and meet the standards of good medical practice in the medical community.
Excluded services	If services not deemed a medical necessity, CDU, Cosmetic, gastric bypass for weight loss.
Presumptive Charity (PARO, SOS and La Amistad programs	Share ourselves program (SOS) and La Amistad have been pre-determined to meet the program guidelines as these individuals were determined to be at or below 200% FPL. SOS and La Amistad complete their own screening and approval. Payment Assistance Rank ordering (PARO) Score: PARO is a patient account scoring mechanism. PARO score is evaluated bi-annually and calibrated to reflect the charity care policy of Hoag for evaluation and eligibility criteria.
Medicare	Medicare is a federally funded health insurance program for qualified people age 65 or older. Certain people younger than 65 also qualify based on disabilities or renal disease. This program helps with the cost of health care, but it does not cover all medical expenses or the cost of long-term care. It is not based on low-income. It is not part of the Health Insurance Marketplace, but there are some coverage changes as a result.
Medicare Payment Rate	The average amount of payment the Hospital would receive from Medicare for providing services. This rate is Hospital-specific and updated periodically.
Payment Arrangements / Installment Plans	A plan negotiated and agreed to by the Hospital and the patient that sets the terms of extended payment for services provided by the Hospital. Any pre-service payment plan is based on an estimate and the financial counselors and/or schedulers coordinate payment plans through the self-pay supervisor as Final terms are set up after final billing.
Reasonable Payment Plan (CA)	If Hoag and the patient/guarantor, cannot agree, the Hospital shall create a reasonable payment plan Monthly payments pursuant to a reasonable payment plan cannot exceed more than 10 percent of a patient's family's monthly income, excluding deductions for essential living expenses.
Essential Living Expenses (CA)	Expenses for any of the following: rent or house payment and maintenance; food and household supplies; utilities and telephone; clothing; medical and dental payments; insurance; school or child care; child or spousal support; transportation and auto expenses, including insurance, gas and repairs, installment payments; laundry and cleaning; and, other extraordinary expenses.

Policy

Category: REVENUE CYCLE	Effective Date: See footer
Owner: Executive Director, Revenue Cycle	
Title: Financial Assistance Policy	

Attachment A: Hoag Notice of Availability of Financial Assistance

Mission

Our missions as a non-profit, faith-based hospital is to provide the highest quality health care services to the communities we serve.

What is the Patient Financial Assistance Program?

Hoag Hospital's Financial Counseling Department offers free financial screenings for people who do not have health insurance and cannot pay their hospital bill, as well as patients who do have insurance, but are unable to pay their portion of the bill that insurance does not cover.

Our Financial Counselors will review your eligibility for Medicare, Healthy Families Program, Medi-Cal, or other coverage offered through the California Health Benefit Exchange, California Children's Services program, other state- or county-funded health coverage, or charity care. If you already have coverage through one of these programs please notify our Financial Counselors immediately. Patients ineligible for government assistance may still qualify for discount or charity programs available through Hoag Hospital.

How and When to Apply

Please contact our Financial Counselors immediately after discharge or completion of services by calling 949-764-5564 or by e-mail at FC@hoag.org. We can assist with your application and provide the applications for Medicare, Healthy Families Program, Medi-Cal, or other coverage offered through the California Health Benefit Exchange, California Children's Services program, other state- or county-funded health coverage. You may also be referred to www.OCGOV.com for local assistance.

If you lack, or have inadequate, insurance, and you meet low- and moderate-income requirements, you may qualify for discounted payment or charity care. Please remember that access to necessary health care is not affected by eligibility for financial assistance. Hoag Memorial Hospital is committed to treating all those who come to us for care.

You may also apply directly for the above programs by accessing their website directly:

Medi-Cal: http://www.dhcs.ca.gov/services/medi-cal/pages/applyformedi-cal.aspx

Affordable Care Act: www.HealthCare.gov to apply by phone Call 1-800-318-2596

Medicare: www.ssa.gov/medicare/apply.html

Hoag Charity care program: www.Hoag.org (Patient & Visitors tab, Billing, Charity Care Application)

Confidentiality

We understand that the need for financial assistance can be a sensitive and deeply personal issue. We are committed to maintaining the confidentiality of requests, information and funding.

For more information please contact one of our Financial Counselors at 949-764-5564, we are available Monday through Friday from 8:30 AM to 4:30 PM, or by e-mail at FC@hoag.org.

Policy

Category: REVENUE CYCLE	Effective Date: See footer
Owner: Executive Director, Revenue Cycle	
Title: Financial Assistance Policy	

Reference:

References

These publications are relevant to this document:

Document Type	Title
Process	Collection Process for Patient Financial Services
Policy	Financial Counseling – Government-Funded Insurance (RCS.13)
DLP	Offering Payment Arrangements
Policy	Patient Discounts (RCS.26)
Policy	Payment Arrangements (Installment Plans) (RCS.18)

Review and/or input for this procedure was given by the following:

Revision Designation:

APPENDIX B

Hoag Hospital Quantifiable Community Benefit Summary Trend CY 2018

A. Unreimbursed Cost of Direct Medical Care Services - Charity Care

Definition: The direct cost of medical care provided by Hoag; consists of unreimbursed costs (calculated utilizing cost-to-charge ratios) of providing services to the county indigent population, charity care, and care provided to patients identified and referred by the SOS Medical and Dental Clinic

		CY 2018	CY 2017 STUB*
[1]County Indigent Programs	$	8,377	13,381
Charity Care	$	5,630,321	3,654,304
MediCal/Cal Optima Cost of Unreimbursed Care	$	42,628,563	18,076,472
Medicare Cost of Unreimbursed Care	$	100,666,468	35,755,839
Total Cost of Unreimbursed Direct Medical Care Svcs	**$**	**148,933,729**	**57,499,996**

B. Benefits for Vulnerable Populations

Definition: Services and support provided to at-risk seniors and children, the indigent, uninsured/underinsured and homeless to facilitate access to preventive and immediate medical care services.

Community Health Services	$	1,108,887	$	498,401
Subsidized Clinical Specialty Services	$	1,574	$	931
Cash and In-Kind Contributions	$	7,801,318	$	4,110,745
Community Benefit Operations	$	1,467,648	$	790,346
Total Benefits for Vulnerable Populations	**$**	**10,379,427**	**$**	**5,400,423**

C. Benefits for the Broader Community

Definition: Health education, prevention and screening programs, information and referral services, and supportive services available to community residents.

Community Health Services	$	753,492	$	371,751
Health Profession Education	$	34,665	$	106,276
Subsidized Clinical Specialty Services	$	114,149	$	63,257
Cash and In-Kind Contributions	$	3,724,586	$	1,159,567
Community Building Activities	$	-	$	1,260
Total Benefits for the Broader Community	**$**	**4,626,892**	**$**	**1,702,111**
Total Community Benefit and Economic Value		**163,940,048**	**$**	**64,602,530**
Total Community Benefit and Economic Value (excluding Medicare Cost of Unreimbursed Care)		**63,273,580**	**$**	**28,846,691**

Notes:

**The CY 2017 STUB Year included 6 months: July 1, 2017 through December 31, 2017*

1. The MSI Program ended in 2013, replaced by the Medical Safety Net (MSN) Program.

APPENDIX C

Benefits for Vulnerable Populations

Net CB Expenditure

Community Health Improvement Services

Mental Health Center-Community Health	$	885,805
Center for Healthy Living Community Programming	$	223,082
Total Community Health Services	***$***	***1,108,887***

Subsidized Clinical Specialty Services

ECU Call Panel	$	1,574
Total Subsidized Clinical Specialty Services	***$***	***1,574***

Cash and In-Kind Contributions

Academy of International Dance- Healthy Lifestyle Program	$	20,500
Access California Services	$	70,000
Age Well Senior Services	$	50,000
Alzheimer's Family Services Center	$	1,724,639
America on Track	$	26,667
Boys and Girls Club of Santa Ana	$	25,000
Braille Institute	$	25,000
Casa Teresa	$	25,000
CHOC Foundation	$	253,333
City of Huntington Beach	$	48,333
Community Health Initiative of OC	$	40,000
Community Senior Serve Inc	$	16,667
Waymakes (formerly Community Services Program)	$	13,333
Council on Aging Orange County	$	120,000
Families Forward	$	80,000
Healthy Smiles for Kids OC	$	50,000
Human Options	$	30,667
Intervention Center for Early Childhood	$	16,000
Kid Healthy (One OC)	$	36,667
Kiwanis Costa Mesa	$	10,000
Laguna Beach Seniors	$	30,000
Latino Health Access	$	156,000
Laurel House	$	35,000
Mary's Shelter	$	20,000
Mercy House	$	5,000
Mika Community Development Corp	$	5,000
Miracles for Kids	$	23,333
MOMS Orange County	$	255,000
National Alliance of Mental Health (NAMI)	$	80,000
Newport Mesa Spirit Run Scholarship Program	$	8,000
Newport Mesa Unified School District	$	296,667

OC Community Housing Corp	$	50,000
OC Rescue Mission	$	10,000
Pediatric Adolescent Diabetes Research Education Foundation	$	180,760
Project Self Sufficiency	$	20,000
Providence Speech and Hearing Center- Low Income Program	$	150,000
Save Our Youth (SOY)	$	65,000
Second Chance OC	$	10,000
Segerstrom Center for the Arts	$	33,333
SENECA Family of Agencies	$	33,333
Senior Transportation (6 agencies)	$	675,000
Serving Kids Hope	$	150,000
Serving People in Need (SPIN)	$	15,000
Share Our Selves Corporation	$	2,113,957
Shoes That Fit	$	23,333
Someone Cares Soup Kitchen	$	175,796
Special Olympics Orange County	$	33,333
Strength in Support	$	30,000
Susan G Komen	$	58,333
Talk About Curing Autism	$	15,000
The Cambodian Family	$	100,000
The Wooden Floor	$	38,333
TIYYA Foundation	$	10,000
United Cerebral Palsy Association of OC	$	143,334
Veterans Legal Institue	$	30,000
Wiseplace	$	20,000
Young Lives Redeemed	$	21,667
Total Cash and In-Kind Contributions	***$***	***7,801,318***

Community Benefit Operations

Community Health Department Operations	$	832,561
Dedicated Staff	$	624,360
PARO Decision Support (Predictive Modeling for Healthcare)	$	10,727
Total Community Benefit Operations	***$***	***1,467,648***

Total Benefits for Vulnerable Populations $ 10,379,427

Benefits for the Broader Community

Net CB Expenditure

Community Health Improvement Services

Community Education and Outreach (various Hoag departments)	$	307,930
Flu Immunization Clinic Expenses	$	66,717
Health Ministries Program	$	275,654
OB Education Classes	$	23,613
Project Wipeout	$	79,578
Total Community Health Services	***$***	***753,492***

Health Professions Education

Hospital Case Management Internships	$	24,175
Pharmacy Student Clinical Rotations	$	2,090
Rehab Therapy Internships	$	8,400
Total Health Professions Education	***$***	***34,665***

Subsidized Clinical Specialty Services

ETOH/Psych/Ancillary Patient Transfer Program	$	114,149
Total Subsidized Clinical Specialty Services	***$***	***114,149***

Cash and In-Kind Contributions

AIDS Services Foundation	$	40,000
Alzheimer's Orange County	$	116,667
American Lung Association	$	5,000
American Red Cross	$	50,000
Better Breathers Support Group	$	3,872
Big Brother Big Sisters Of Orange County	$	60,000
CHOC Pediatric Diabetes Services at the Allen Diabetes Center	$	789,344
Children's Cause Orange County (One OC)	$	20,000
City of Irvine	$	20,000
Clinic in the Park (One OC)	$	50,000
Crime Survivors Inc	$	50,000
Crohn's & Colitis	$	20,000
Epilepsy Support Network	$	35,000
Hands Together a Center for Children	$	13,333
Health Funders Partnership of OC (One OC)	$	20,000
Hurtt Family Health Clinic Inc.	$	15,333
Infectious Disease Association of California	$	10,000
In-Kind Office Lease/Meeting Space for Non-Profits	$	711,769
Irvine Children's Fund	$	40,000
Irvine Public Schools Foundation	$	66,667
Marshall B Ketchum University	$	12,600
Melody Women's Health	$	150,000
Newport Mesa Schools Foundation	$	16,667
Orange County Asian and Pacific Islander Community Alliance (OCAPICA)	$	33,333
Orange County Bar Foundation	$	30,000
Orange County Community Foundation	$	1,000,000

Orange County Grantmakers	$	15,000
Orange County Human Relations	$	130,000
Orange County United Way	$	25,000
Our House Grief Support Center OC- Camp Erin	$	20,000
Pacific Symphony	$	15,000
People for Irvine Community Health (DBA 211 OC)	$	50,000
Shanti Orange County	$	20,000
Sweet Success Extension Program (SSEP)	$	11,667
The Center Orange County	$	41,667
Trauma Intervention Programs Inc.	$	6,667
Vietnamese American Cancer Foundation	$	10,000
Total Cash and In-Kind Contributions	***$***	***3,724,586***

Community Building Activities

Community Disaster Readiness	$	-
Total Community Building Activities	***$***	***-***

Total Benefits for the Broader Community $ 4,626,892

Prepared By:

Michaell Rose, DrPH, LCSW
Director, Community Benefit & Department of Community Health
Telephone: (949) 764-6278 Email: Michaell.Rose@hoag.org

Minzah Z. Malik, MPH, MBA
Manager, Community Benefit Program
Telephone: (949) 764-6597 Email: Minzah.Malik@hoag.org

Lauren Tabios, MPH
Coordinator, Grants & Special Projects
Telephone: (949) 764-5321 Email: Lauren.Tabios@hoag.org